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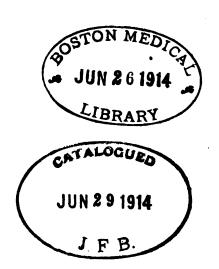
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VOLUME XX

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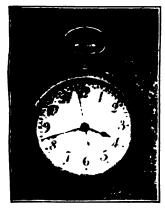
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Vol. xx.

A CONTRIBUTION TO THE STUDY OF BROAD-LIGAMENT CYSTS.

By Myron H. Parmelee, M. D.

THE conclusions which are at the present time held by the majority of authors, when calling attention to broad-ligament cysts, may be fairly stated in general terms as follows:

- 1. They are of slow growth. (Wood, page 675.)
- 2. They rarely attain a larger size than an orange. (Bland Sutton, page 99.)
- 3. The cyst is usually unilocular. (Clifford Allbutt, page 845.)
- 4. They almost never suppurate. (This is disputed by several, but affirmed by Pean, vol. iii. page 685.)
- 5. The peritoneal and ligamentary covering is usually thin and easily stripped off from the sac proper. (Bland Sutton, page 98.)
- 6. They do not often contract adhesions. (Pean, vol. iii. page 688.)

There are other generalizations that might be stated, indeed, which it would be necessary to detail, were one to attempt an exposition of these growths.

Those who are familiar with the current literature of this subject will, I believe, bear me out in the assertion that these are the prominent points of our present knowledge of broad-ligament cysts, in so far as relates to their gross appearance and to points concerned in their removal by an operation.

It is believed, as you may readily conceive, from the above statements, that operations for their removal are not imperatively demanded, and that, when undertaken, they are a matter of easy accomplishment.

American writers are divided in almost all of the generalizations expressed above. In fact, there is no universality of opinion to be found in France, England, or America. The following cases then are contributed to aid in the study of these broad-ligament cysts, first, for their marked deviations from the general rules laid down, and second, for the difficulties encountered in handling them.

CASE I. Miss Anna H., colored, age thirteen, schoolgirl. Came under my observation October 18, 1895, and with the following history:

Father and mother living and well. When about eleven years old had first become conscious of a lump in her abdomen, left side and low down. First menstruated when twelve. Menses somewhat irregular as to time, as to pain and as to quantity always. Pain sometimes before and then sometimes during the flow.

In March, 1895, while skating, received a fall upon the ice, striking a hummock or something with the abdomen. Soon thereafter, pain followed in the left pelvis, which, accompanied by fever, lasted for several days and then subsided, leaving only a soreness to touch in its wake. In

ly, after an unusual exposure and exertion, she had a series of slight chills. In September, chills, fever, and night sweatings returned and lasted until I saw her. Her bowels are fairly regular, but she complains of constant desire to urinate. Bimanual examination reveals a doughy mass filling left pelvis and protruding into vagina. Fluctua tion not clearly made out. Uterus pushed up out of reach

of finger. Mass immovable, and size of a small apple. Temperature at time of examination 102¹/₂°. Pulse, 112.

Operation.—November 4, 1895. Abdominal section; Trendelenburg position. Came at once upon mass under the broad ligament. Tube could be followed, but no ovary could be made out. Section of the dull-red ligament showed it to be, by measurement, one-quarter inch in thickness. Then I came upon the pearly glistening sac of an ovarian cyst, within which we found and evacuated three ounces of pus by aspiration. In order to enucleate I incised the ligament four inches; but found, owing to the intimate adherence everywhere of the ovarian sac to the thickened ligamentous capsule, enucleation to be an impossibility for these reasons:

- 1. The profuse hemorrhage every time I attempted to tear the sac from the capsule.
 - 2. The intimacy of the adhesions.
- 3. The thickness and stiffness of the investing ligamentous tissues, which so interfered with both sight and touch.

Determining, therefore, that an uncompleted operation was better, under the circumstances, I cut away as much of the sac as was possible; made a counter opening into the vagina for drainage, and sewed the edges of the thickened ligament into the abdominal wound, leaving through and through drainage with iodoform gauze.

Result—Death, November 9. The pyæmic symptoms predominating.

CASE II. Mrs. H. P., American, married, age forty-nine, housewife, no children, no miscarriages. Began to menstruate at fifteen; has always suffered pain at her periods and for the last ten years would menstruate every two weeks, with terrible headaches, until ten months ago. Then her menses ceased. Soon thereafter began to notice a steady enlargement of her abdomen. Friends and her doctor thought she was pregnant, but passing the time for a labor, she was brought to me, February 16, 1897. Abdomen as large as a full term pregnancy; but projecting to the

left and straight out from the pubes. Fluctuation well marked. Right leg ædematous. The entire pelvic region tender to touch, and shooting, knife-like pains have been frequent. Uterus pushed up beyond reach and vagina encroached upon from left side.

Operation.—February 20, 1897. Abdominal section; Trendelenburg position. Incision high up to avoid bladder. at first four inches in length, later lengthened to eight inches to obtain room to work through. At once it was apparent that the cyst had developed under the broad ligament. After incising the ligament I began enucleating from without inward, and then, from within outward. Hemorrhage was pretty free but was controlled by forcible pressure, until the bottom of the pelvis was reached from each side. During the enucleation I ran into and ruptured five small budding cysts, but as the fluid which they contained was colorless it was simply taken away with gauze sponges. On reaching the pelvic floor it was apparent that here the sac was more intimately adherent than elsewhere, and that in enucleating along the left uterine wall, I had stripped the uterus of all its peritoneal coat. This necessitated an immediate hysterectomy, which was made, leaving the cervix buried, after the method of Baehr. Finding it not expedient to attempt further enucleation, and first releasing about six inches of adherent intestine, I cut all of the ligament and sac that was freed away, and then sewed the edges together over the remnant of ovarian sac which lined the pelvic floor, and after irrigating with normal salt solution, closed the abdomen. This patient did well until the eighth day, when her temperature ran up to 102°, and pulse 120; the next day to 104° and 140, but fell somewhat the next day, with the discharge of pus both from the bladder and the lowest point of abdominal incision. I had undoubtedly wounded the bladder during the operation. Notwithstanding this annoying complication the patient did well and was sent to her home in good condition on the 14th of April.

CASE III. Miss Lottie G., American, age twenty, unmar-

ried, no occupation, was referred to me with the following history: About one year ago a large ovarian dermoid, left side, which had been growing slowly in her abdomen, was removed by operation. Six weeks ago she fell from a fence, since which time she had had a great deal of pain in right pelvic region. No menses for some months. Is now taking one-quarter grain of morphine every two hours, and is in a deplorable general condition.

A bimanual examination reveals a bunch in right pelvis which projects into vagina, is very tender to the touch, is elastic, but not clearly fluctuant, and is of the size of a large egg. Owing to her very bad general condition I did not care to again open her abdomen.

Operation.—Vaginal section, October 20, 1896. Lithotomy position. Opening into the posterior peritoneal pouch, and from thence into and under the right broad ligament, my incision gave exit to a small quantity of dark-colored thin liquid, and at once masses which had the gross appearance of placental tissue were extruded. A small handful was taken away, as well as all that portion of the containing sac which could be enucleated. Nothing like a fetus could be seen. The cavity was thoroughly irrigated with hot boric acid solution, packed with gauze, and the patient returned to bed. This gauze was removed and replaced, after irrigating, every two days. Vefy little if any discharge after the first opening. Patient went home, October 28, greatly improved.

On referring the specimens to the miscroscopist, he reported as follows:

CASE I. An ovarian cyst, infected by gonococci.

CASE II. A papillary proliferous cyst of the ovary.

CASE III. An ovarian dermoid, undergoing malignant degeneration. These three cases then constitute my present contribution.

I have removed ordinary parovarian cysts from beneath the broad ligament, that were similar to the usual description of such growths, but these cases exhibited such marked deviations that I have ventured to present them as an addition to the sum of our general knowledge.

THE RELATION OF PELVIMETRY TO DYSTOCIA.

BY B. H. OGDEN, M. D.

MUCH attention has been given during recent years to preventive medicine. A scientific study of the causes and course of disease has led to marked improvement in sanitary hygiene and the adoption of effective measures in preventing the development and spread of disease. This idea is destined to extend through all branches of medicine, so that prevention in surgery, gynecology, and obstetrics will be as marked a study as it is to-day in medicine.

Since the days of Semelweiss septic and inflammatory conditions incident to childbirth have lost their terrors, not only because we know better how to treat them, but mainly because we know how to prevent them.

During the past century a great deal of study has been given to the "mechanics" of childbirth, and it is safe to say that the general practitioner of to-day is usually well informed as regards the best treatment of any given case of difficult labor, or impossible birth of a living child, but there is a step in advance of this which it is the object of this paper to emphasize. I refer to the early recognition of those abnormal conditions which make normal labor impossible, and which if unrecognized before full term bring the mother or child—perhaps both—into very great danger.

It is a great achievement when called suddenly to deal with a difficult or impossible normal birth to meet the emergency wisely and skillfully, but it is far better to have recognized the abnormality early in the period of gestation and to have selected such treatment as would prevent the emergency from arising. The fate of the mother and child often depend on the ability of her physician to determine before the time of labor the exact dimensions of the pelvis. He will then be enabled to choose the best time and best method of treatment, and will not be limited to such procedures as an emergency may demand. In this light

pelvimetry becomes a matter of great importance, and, as one writer says, "It cannot be emphasized too strongly that the physician is to-day not guiltless who, whenever it may be, does not practice pelvimetry."

At the risk of being somewhat didactic let me describe briefly the methods most approved. From measuring a large number of cases it has been found that certain external measurements bear a fixed relation to the internal diameters of the pelvic inlet. Various instruments called pelvimeters have been devised for measuring these external diameters. Beaudelocque's pelvimeter is probably the best known, though others are more convenient because more portable. The one I use is called Collier's. By its use the following external diameters are readily obtained, the greatest care being used to adapt the points of the blades accurately to the soft parts.

- 1. Beaudelocque's diameter—eight inches—being the normal distance between the spinous process of the last lumbar vertebra and the middle of the anterior surface of the symphysis pubis. Deducting three inches from this diameter, which is also called the external conjugate, will give the true internal conjugate.
- 2. Distance between the superior spines of the ilium, 10 to 10½ inches.
- 3. Distance between the crests of the ilium, 10½ to 11 inches.
 - 4. Distance between the trochanters, 12 to 121/2 inches.

The most important of these external measurements is the first, and when carefully made gives a fairly accurate estimation of the true conjugate. Any diminution of the measurements before given calls for internal manual pelvimetry, the patient being anæsthetized if necessary. Various instruments have also been invented for making these measurements, but the fingers and occasionally the whole hand give the most satisfactory results. With the patient in the dorsal position, the index and middle fingers are introduced into the vagina and pushed upward and backward until the promontory of the sacrum is reached,

then the edge of the index finger is made to rest against the symphysis pubis and its point of contact marked. Upon the withdrawal of the fingers the distance from the tip of the middle finger to the mark on the index measures the diagonal conjugate, which is about one-third inch longer than the true conjugate.

The transverse and oblique diameters are not so easily measured. If the pelvis is symmetrical and the conjugate normal, we need expect no trouble with a child of average size, but if we should suspect any irregularity which is not otherwise revealed, the whole hand should be introduced into the vagina, the patient having been anæsthetized.

The relation of pelvimetry to dystocia arising from abnormal pelvis is obvious. An early knowledge of any deformity, however slight, will make the physician *master* of the situation.

An operation which, within the last few years, has given good results is the induction of premature labor. If the pelvic contraction is not great labor may be induced at about the eighth month with good chances of saving the child. If the contraction is still greater so that it would be necessary to induce labor at seven months, the danger to the child is much greater, both because it is more feeble then and because of the difficulty of determining the exact time of conception and hence the exact ending of the seventh month. There are certain well established rules indicating at what period of gestation premature labor should be induced for any given degree of contraction, which it is not the purpose of this paper to enter into.

Again, pelvimetry is of great importance as a guide to the election of podalic version. Unless the child is unusually small, version is positively contra-indicated with a conjugate diameter of less than 3½ inches, but with a contraction not greater than this version will often secure a living child where the forces of nature or the forceps would fail. In such cases it is of immense advantage to have recognized the condition before the mother has become exhausted or the child injured by useless attempts of forceps delivery.

In symphyseotomy a previous accurate pelvimetry is indispensable, as only by this means can it be determined whether the diameters will be sufficiently increased by the operation to secure the birth of a living child.

The operation of Cæsarean section is much more successfully performed now, not merely because of improved technique, but the knowledge gained from pelvimetry enables the operator to *choose* the *time* and *place* of operating. If it is too late to secure the birth of a living child by the induction of premature labor, he must choose between symphyseotomy and Cæsarean section, and the degree of contraction as determined by pelvimetry must decide this question.

It is thus seen how important a place is occupied by pelvimetry in relation to dystocia, and yet it is safe to say that very few actually practice it. I wish I might impress upon all its necessity, so that the pelvimeter will be as commonly found in the obstetric bag as the forceps, for I believe its intelligent use will greatly diminish the mortality of children during birth and prevent those terrible cases of labor which are a constant menace to maternity.

Since writing the above the following illustrative case has come under my care. A woman with the history of two very difficult labors, in which the children were killed during birth by the crushing force of the forceps, engaged me to attend her in a third confinement. Careful pelvimetry showed a flattened pelvis, the most common deformity I have met with. The contraction was not very great, the conjugate diameter measuring about 3¾ inches. Her former children were large, weighing ten or eleven pounds. I advised the induction of labor at eight months, and this was accordingly done, and resulted in the birth of a living boy weighing 7¾ pounds. The little fellow is now over a month old and perfectly well. It is needless to say the parents are simply delighted, and I believe the child's life was saved by this procedure.

PUERPERAL ECLAMPSIA.

By W. A. Humphrey, M. D.

Of the many obscure conditions which the medical mind has studied and attempted an explanation, puerperal eclampsia still belongs to the complement of those the cause of which is positively unknown.

Many theories of causation have been advanced, each has had its day, and then in turn has been relegated to the list of doubtful causes. The causation has been attributed to uræmia, hydræmia, ammoniæmia, reflex irritation, microbic influence, or to the influence of some toxic material. The latest, and therefore the most popular theory, is that eclampsia is due to the presence of a toxæmia of autoinfection, of the accumulation in the blood of a toxic material, either biliary, urinary, fetal, or all three. Just what this material is has not been determined. The consensus of opinion, however, is that it has not one, but many causes, all of which may be expressed in the phrase, "toxæmia of pregnancy."

The clinical picture of the toxæmia of pregnancy, or what is better known as the pre-eclamptic state, presents a series of symptoms which are constant, but which may vary greatly in degree. Indeed, they may vary so much that many of the minor ones may be absent entirely. a general way, they present the phenomena of poisoning either by mineral or narcotic poison. The condition being always accompanied by failure of the eliminative organs to do their duty, especially the kidneys. The time-honored symptom of albuminuria is generally present, being absent in from nine to sixteen per cent. of cases. The class of cases in which it is absent are just as fatal as those in which it is present. The urine is generally diminished in quantity with lessened amount of urea. Although the urea is diminished and the stimulation of the kidneys to greater activity generally relieves the symptom of toxæmia, yet we are not to infer that it is the retention of urea that produces the convulsions. It has been conclusively proven that large quantities of urea injected into rabbits produce no toxic symptoms. Furthermore urea may be found in normal quantity, and yet eclampsia occur, as has been proven in many instances. Headache, vertigo, nausea, loss of appetite, sleeplessness, restlessness, with small excretion of urine and constipation are usually present, and if the case is progressing for the worse, a pulse increased in frequency. This picture, or even the shadow, should put the physician on guard and set him to work to avert the awful calamity now threatening. A differential diagnosis seems unnecessary when we have a pregnant woman presenting symptoms pointing to toxæmia. We should not wait to verify the diagnosis until our patient has an eclamptic seizure from which she may never recover, but we should act at once. This brings us to the discussion of the line of treatment to be considered. The treatment is preventive and curative. The former is the all-important one, for eclampsia can be prevented if taken in time. Unfortunately, the physician is not always appealed to in time. Every pregnant woman should go early to her physician and be constantly under his observation. No woman, however timid, can afford to take any chances when in this condition. It is the physician's duty to be on the alert when such patients are under his care, and see that every function is kept in normal condition, as nearly as possible.

Preventive measures mean that the bowels are to be kept from being sluggish, that the kidneys are to be kept active, that the skin is to be kept in good condition. In case there are symptoms of eclampsia, careful attention must be given to the diet. Nitrogenous food increases the tendency to convulsions. Toxic materials due to tissue metabolism of all the cells of the body, constantly menace the patient. Add to this the tissue metabolism of the tissue of the fetus, and we have all the elements of proof to urge the necessity of keeping the eliminative organs active. Reduce every irritation to the minimum. If this

has been done with no result, empty the uterus. Encourage the patient to live upon a milk diet with the addition of plenty of water and fresh air. Encourage the activity of the skin by bathing and keeping flannel next to the body. Careful attention should be given the heart, by administering such remedies as will reduce its frequency, and as do not interfere too much with its force. In case of convulsive attack, empty the uterus as early as possible. The mortality diminishes progressively from ante-partum to the post-partum states. It is greater when eclampsia sets in during pregnancy, is less during labor, and lowest when the attack comes for the first time after delivery. The mortality for eight years at the Boston Lying-in Hospital was: "Ante-partum eclampsia, 46 per cent., fetal mortality, 60 per cent.; intra-partum eclampsia, 25 per cent., fetal mortality, 25 per cent.; post-partum eclampsia, maternal mortality, 7 per cent.

The question as to just when we should interfere and empty the uterus is the one that is most difficult to decide. In a given case in which we suspect danger, unless we succeed in keeping up elimination and in establishing a normal equilibrium, the induction of labor is justifiable, or in case labor has set in and eclampsia supervene, rapid delivery is the only safe process. This is best accomplished under profound anæsthesia from chloroform. Let us emphasize the word profound. No halfway anæsthesia is here permissible; give the patient chloroform until all reflexes are destroyed and proceed to deliver. Delivery is performed best when we have full dilatation, but we must not always delay on this account. If the uterus is dilated sufficiently for instrumental delivery, put on the forceps and deliver as fast as consistent. One should not hasten recklessly through an undilated os to add to the danger already existing. In case we are unable to apply the forceps, as is sometimes the case, deliver by podalic version. The womb once emptied of its contents, must now be guarded from hemorrhage, which will threaten with our patient in profound anæsthesia. Careful attention to this will avoid

sacrificing life oftentimes, where timely interference would have saved the patient. These details are not always an easy matter. For instance, we are called to see a woman already in an eclamptic state, and we find no dilatation, what shall be done? We must now proceed along different lines. Given, a patient unconscious with toxæmia, and having already had an eclamptic seizure, and there is present a full rapid pulse, give veratrum viride tincture. Give five drops every half hour or hour until the pulse is reduced to sixty or below. If consciousness return, slow dilatation may be practiced. If not, add to this profound anæsthesia and use forcible dilatation by the use of dilators, or by the use of the fingers, and later, the hand of the accoucheur. Only in extreme cases is one justified in making deep incision in the cervix, for the purpose of rapid dilatation. When deemed wise to employ this procedure, the incision will be done more safely with strong scissors. The point of incision should be in the anterior superior portion of the cervix and should be repaired as soon as delivery has been accomplished, if possible.

Having accomplished delivery, we now turn our attention to the mother. We must now set to work the organs of elimination. How can this best be done? Unless contra-indicated by a weak heart, no remedy is so valuable as veratrum viride, in appreciable doses. Give five drops every half hour or hour until the pulse is sixty or lower, and then regulate the dose so as to keep it there. Why do we proceed thus? Because convulsions are practically unknown with a pulse of sixty; because veratrum stimulates the skin and kidneys to greater activity, and because long observation by the profession proves it to be the king of remedies in puerperal eclampsia.

But there are others. A weak heart may direct us to others, such as digitalis, glonoine, gels., etc. Morphine is often required where chloroform or veratrum are contraindicated, but should be used cautiously. Many physicians claim that it should never be used, because it adds to the already existing stupor, and thus increases the patient's

hazard. Careful flushing of the bowel will add materially to the patient's chances of recovery. Later, after the danger from convulsions has passed, merc. cor., apis, ars., or any kindred remedies may be indicated. It has been the aim of this paper to point out the dangers of eclampsia and the emergency treatment. Early, careful attention to these cases will avoid them and reflect more credit to the attendant than faithful attention after it is too late.



PRENATAL MEDICATION.*

BY GEORGE ROYAL, M. D.

COMEONE has said, "It is the inalienable right of every O child to be well born." The strongest argument in favor of this proposition was that only by being well born could an individual attain that degree of perfection, both mental and physical, which it is his privilege to possess. In connection with this statement, I want to couple another, viz.: That under the existing social conditions. taking into consideration what has been inherited and what is being added to that inheritance by our present mode of living, few children can be well born in the full sense of that term without the assistance of the physician. Furthermore, that assistance must be rendered for a considerable period prior to birth. It is unnecessary for me to present the facts to prove this statement. You can all think of twenty reasons, in as many minutes, why it is true. And because it is true, it is also evident that the physician who wishes to succeed in the treatment of diseases of children must study, understand, and be able to modify the causative influences which exist in the parents. For success in the treatment of certain diseases of children depends upon and is commensurate with the knowledge and skill in detecting and modifying those parental influences which are the predisposing causes of the diseases. Of the many parental influences, I have selected one for our consideration to-day, viz., the influence exerted by the dyscrasias, the most important of which are syphilis. tuberculosis, and their product, scrofulosis. For I am confident that not only may the children of syphilitic and tuberculous parents be scrofulous, but that these children may, in turn, transmit scrofulosis to their offspring. these two or three conditions we may add rickets, cretinism, the gouty diathesis, and certain neuroses. Feeling

^{*} Read before the Hahnemann Medical Association of Iowa.



sure that the simple mention of these diseases will help you to recall their ætiology, symptomatology, and what little is known of their pathology, I will waste no time in recapitulation but will pass at once to what is more practical and useful, i. e., the homeopathic treatment or therapeutics. "What," I hear someone say, "can you do anything for the unborn children of parents afflicted by these dyscrasias by the exhibition of drugs during gestation?" I answer most emphatically, "Yes." If I did not believe, aye, if I did not know that drugs administered homeopathically can do much to help such children be well born, I would cease to teach if not to use our materia medica.

Remedies.

Sulphur 30th.—The pregnant woman is tall, the skin is dry and dirty, the hair is coarse and dry, hangnails are abundant about the brittle finger nails; there are itching pimples upon the face, which burn when scratched; you see a little cut which the patient says smarts and is sore, the surrounding tissues are inflamed and there is a little pus; the itching, the burning, and the soreness of the injured tissues are all made worse by bathing. On the neck is a scar which shows that a gland suppurated when she Her restless sleep has always been diswas a child. turbed by dreams; she has been habitually constipated and a sufferer from hemorrhoids. The menses have always been late and scanty. On several occasions they have been suppressed, at which times she suffered from a most violent congestive headache with heat and weight on the vertex and coldness of the feet. By the time you have elicited the above symptoms, the patient will have become so impatient and irritable that you will want a dose of sulph. administered to her at once, especially will this be true if your sense of smell is acute; for the sulph. patient always has a filthy odor. All the excretions have a bad odor and often excoriate.

I know that in this age of fickleness, folly, and fads, the

man who mentions sulphur is looked upon as a back number and dubbed an old fogy. He is informed that science has demonstrated that it is useless as a disinfectant, that the power formerly ascribed to it of being able to produce a reaction is mythical, that in its pathogenesis are so many symptoms that none is genuine. The men who say these things have never used the remedy and on this account are eminently competent to speak of its worthlessness.

Hepar sulph.—If, on the other hand, your patient is fleshy instead of spare, if the skin is always moist instead of dry, if the hair is also moist and greasy, if there be much more suppuration about the finger nails and abraded surfaces, with soreness and moisture between the folds of the skin, if there be a bad odor to both excretions and secretions, if the glands have a tendency to enlarge, if the pains are sharp and splinter-like, if the patient has always been extremely sensitive to cold, dry air, if instead of having come to see you, you have been sent to her and have found her too indifferent about herself to take any interest in her own case, give the patient hepar.

Calc. carb.—If your next patient be of the same make up as the hepar patient, if you have the same moisture of the skin but more about the head and shoulders, if the bones have been soft and spongy, if there be more swelling but less suppuration than under either hepar or sulphur, if she has a record of too profuse and too frequent menses, if there be an aggravation from water as there was in the sulph. patient but, instead of the itching, burning, and soreness of wounds being made worse by water, it is the swelling, stiffness, and rheumatism which is not only aggravated but caused, if, in addition, you have the history of a cough and a tendency to serious lung trouble at the age of puberty and if coldness of the hands and feet be marked, you have a good picture of calc. carb.

Natrum muriaticum should not be forgotten when you have a history of mental depression, anæmia, and emaciation at the age of puberty. The nervous phenomena at

that time were also marked. The patient will tell you that the health has never been good. That there have always been weakness, constipation, delayed and scanty menses, but a profuse, acrid, greenish leucorrhœa, the appetite has never been good, that she has always suffered from sour eructation, heartburn, and often vomiting, that the tongue has most always had patches upon it. Give your nat mur.—the 200th.

Kali carb.—With nat. mur. associate in your mind kali carb., because kali will often finish the work which has been begun but only partially completed by natrum. This patient will also tell you that she has never been well, Her pulse has always been soft and weak. Her bowels have been constipated. The stools large and light colored. She has had almost constant trouble with her liver. The skin has been dry, sallow, and often yellow. The patient may be fleshy but the tissues are wanting in vital force and heat. The menstrual history is unlike that of nat. mur. but similar to calc. carb. There may have been frequent suppression, but as a rule the menses are too early and too profuse, nearly always painful, the pains sharp and cutting. But the most characteristic symptoms of kali carb. are sensitiveness to cold, either dry or moist, a peculiar, dry, hacking cough which only occasionally gets under the very scanty expectorations of round lumps of mucus, and the early morning aggravation.

Mercurius.—If the patient presents a history of foul breath, of a tongue whose base is always coated, of spongy gums which bleed easily, of decayed teeth, of frequent swelling of the glands about the neck, of frequent attacks of diarrhea when the stools are pasty, green, and mucous, are preceded by pain and followed by straining, if there has been chronic subacute ovaritis, if there have been frequent uterine hemorrhages, if the skin has been unhealthy, there having been moist eczema or indolent, bleeding ulcers, if the patient perspires easily and yet none of the conditions are relieved by the perspiration, and if above all there have been pains in the long bones aggravated by

damp weather, at night, and essentially by the warmth of the bed, give mercury. And as these symptoms are more or less modified, use the different compounds of mercury. During the remaining few seconds of the ten minutes allotted me, let me simply mention thuya, staph., calc. phos., arg. nit., zinc, and iodine. I have also used psorinum and tuberculinum.

At a meeting of this society eleven years ago, I hinted that something could be done in this line. For the past ten years I have made observations of the children of the same parents, comparing for the first thirty months of babyhood the health of those born before and that of those born after the exhibition of some of the above remedies. The result has been more satisfactory than I had expected. As many of our patients consult us during the first weeks of gestation, at which time I believe they are especially susceptible to the action of such drugs, you have many opportunities for securing such records; therefore in closing, let me urge all of you, but especially the younger members, to improve these opportunities, and ten years from now come with your case books so filled that we shall have data for a scientific demonstration of the truth or falsity of my theory.



LACERATIONS OF THE CERVIX UTERI.*

By ABBIE A. HINKLE, M. D.

L ACERATIONS of the cervix uteri are of such common and frequent occurrence, and produce such serious consequences, that this lesion is recognized as one of the most important in the diseases of women.

Parturition, natural or instrumental, is usually the cause of this injury; many cases are due to criminal abortion, especially after the third month of gestation. In the majority of first labors the cervix is injured to some extent. but, in many cases, healing takes place during the lying-in, or the injury is superficial and no serious results follow. Some conditions of the cervix predispose to lacerations. which cannot always be prevented by the greatest care and skill of the obstetrician. In abnormal labors requiring manual and instrumental interference before dilatation, there is great liability to injury. The severest lacerations are generally produced by forcibly extracting the head through an imperfectly dilated os. They are sometimes the result of precipitate delivery in easy, rapid labors, but more commonly of protracted labors and instrumental delivery. Post-partum hemorrhage is likely to follow a severe laceration; also, septicæmia, from the lochial discharge entering the raw surface. Later, the patient's general health is seriously affected and there is a marked disturbance of the reproductive organs, the gravity of which depends upon the character and extent of the lacerations.

It has been authoritatively stated that three-fourths of the uterine disorders of those who have borne children are due to lacerations of the cervix. They are the origin of most chronic uterine disorders—enlargement and hardening of the cervix, cervical catarrh, erosion of the mucous membrane (which is sometimes described as granulation or

^{*}Read at the Forty-second Annual Session of the Illinois Homeopathic Medical Association, May 12, 1897.



ulceration of the cervix), metritis, endometritis, cellulitis, sub-involution, and epithelioma.

Surgical repair.—Emmet's operation (hystero-trachelor-rhaphy) should be resorted to early when the laceration is extensive. Restoration of the cervix relieves the inflammatory condition and the suffering from scar tissue, causes complete involution, and a marked decrease in the size of the uterus—where, owing to sub-involution, it has been larger than normal; and sometimes cures sterility. In sub-sequent labors, there is no increased risk of laceration; the results are greatly in favor of those who have had the cervix restored, as compared with others having lacerated cervix with scar tissue. Emmet's operation, performed in early pregnancy, has also been the means of arresting threatened abortion.

Proper diet, the indicated homeopathic remedies, and hygienic habits during pregnancy, frequent hot sitz baths and olive oil rubbings for several weeks prior to parturition, and skillful management of the obstetrician during labor will ensure safe and comparatively easy labor and avoid lacerations, except in extremely rare instances.

The following instances (from a large number of cases) will suffice to show the correction and cure of abnormal and diseased conditions by trachelorrhaphy.

CASE.—Mrs.—, æt. forty-one, had suffered many years from endometritis, prolapsus, erosion of the cervix and profuse leucorrhœa; also, insomnia, severe headaches, and general nervous debility. Emmet's operation (performed by Professor Ludlam) restored the cervix, and the cure of the above-named disorders was gradually effected thereby. Two years after the operation she gave birth to a healthy daughter, and instead of dragging out a miserable existence as for so many previous years, she is in the enjoyment of health and happiness.

CASE.—Mrs. —, æt. twenty-six, I attended in labor in the spring of 1891, when she was delivered of a male child, which was her fifth living child, and she had experienced three miscarriages. I discovered that, during a former parturition, there had been extensive lacerations of the cervix and perineum. When the infant was nearly a year old, after the return of the menses, I recommended surgical repairs. When ready for the operation on two different occasions, she became pregnant, but, owing to the condition, miscarried, At last the propitious time arrived and the cervix and perineum were operated on with good results. She has since borne two strong, healthy, male children, and the cervix is in excellent condition; her general health and strength are up to the normal standard.

CASE.—Mrs. —, æt. twenty-four, mother of two children (æt. three years and one and a half years respectively), suffered from profuse leucorrhœal discharge, backache, headaches, weakness, and constant weariness. Upon digital examination and use of speculum I found prolapsus, intense inflammation of the cervix, endometritis, and sub-involution, the result of laceration of the cervix. After a few local treatments with medicated tampons and hot vaginal douches; also bell., ham., and calc. fluor., given for constitutional remedies at different times, the cervix was restored, and the young wife feels strong and happy-hearted since the change from weakness to perfect health, four months having elapsed since the operation.



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DILATING AND CURETTING IN UTERINE HEMORRHAGE.

By S. A. Bass, M. D.

NEARLY every physician knows what it is to be called upon to treat uterine hemorrhage, and how perplexing it is when you think you have the case nearly cured to have hemorrhage occur worse than ever. These cases are not very common, but spring up now and then, and the patient goes from one physician to another and usually has the benefit of nearly every kind of a hemostatic. They become very much discouraged, and think the physician does not understand his business because he has not accomplished the result they have been looking for.

Such a case came to me eighteen months ago, and after examining my patient thoroughly I discovered the endometrium in a badly granulated condition and I told her it was useless to give medicine or apply local treatment, as they would not cure but merely act as palliative treatment and only afford temporary relief. I advised dilating and curetting as a radical cure, but the thought of taking chloroform and going through with an operation seemed shocking to her, and she wished me to give her a trial of medicine first, so I put her on medicine and during this time she consulted other physicians as to the advisability of this form of treatment.

She even took a trip back to her former home in Illinois to consult her old family physician, to see if there was not some possible way to avert the operation, but he only advised her to have the operation performed by all means as soon as she returned home if the hemorrhage occurred again.

Soon after her return she called at my office to let me know that she was cured, as she had had no return of hemorrhage for over ten weeks, and was feeling very much elated to think that perhaps she would not have to undergo the operation. I felt very much pleased to think that my

treatment had been so effectual as to bridge her over so long a period, the longest she had ever gone for three years, and for her benefit I hoped it would prove to be a permanent cure.

Strange to say all the physicians she had consulted advised her to carry out my form of treatment, and she was determined to have it done provided hemorrhage should ever take place again.

Imagine my surprise the next day to have her call at my office again, very much discouraged and disheartened, because she had had one of the worst hemorrhages she had ever had, and had decided to have the operation performed as soon as possible.

This was Tuesday, and we made all arrangements for the operation on the following Thursday, July 16, 1896.

With the aid of four assistants I commenced the operation. Patient was anæsthetized and limbs supported by two assistants. My first procedure was to insert guy ligatures in the anterior and posterior lips of the cervix, uterus brought down and held by guy ligatures. Dilatation was performed by the Pratt graduated uterine dilators to the largest size, after which the Holbrook irrigating curette, attached to a fountain syringe which contained a boracic acid solution, was used and endometrium entirely smoothed of all granulations and fungosities. I was expecting that hemorrhage would take place while curetting, but instead it seemed to check all hemorrhage at once.

After curettage the uterus was thoroughly dried out and packed with iodoform gauze, which was allowed to remain forty-eight hours before removing. After removing I placed a second packing, which remained twenty-four hours longer. Calendula and glycerin tampons were then used every other day for two weeks, which completed the after treatment.

My patient began to sit up after the second week, and in four weeks' time was able to assist in the larger part of her household duties.

Shortly after this she was called upon to test the efficacy

of the operation. Her daughter came to visit her, and while there was taken sick and she was obliged to wait on her, being on her feet night and day for nearly four weeks without any return of the trouble.

She has often remarked since the operation that she feels as light and as young as she ever did when she was sixteen years old.

It has now been nearly one year since the operation was performed, and no sign of any hemorrhage has ever been discovered.

ON THREE RECENT CASES OF MALIGNANT DISEASE OF THE UTERUS, TREATED BY HYSTERECTOMY, WITH GENERAL REMARKS ON DIAGNOSIS, AND ON THE EARLY AND LATE RESULTS OF OPERATION.*

BY EDWIN A. NEATBY, M. D.,

Assistant Physician for Diseases of Women to the London Homeopathic Hospital.

THESE cases are of interest on account of their gravity, of the differences which they present under comparison, and because they have all come under observation and treatment during the last three months.

CASE I. On February 12, H. K., a married woman of fifty years of age, came to the out-patient clinic of the London Homeopathic Hospital on account of laceration of the perineum, which prevented the patient from having control of the bowel-sphincter. She also stated that she had been suffering from hemorrhage from the vagina since August, 1896. Prior to that she had been regular for three months, after having had a term of nine months' freedom from any menstruation or bleeding of any kind. Latterly she had used two or three diapers daily. The discharge was odorless. If the bleeding ceased it was replaced by

^{*} Presented to the Section of Surgery and Gynecology.

yellow or white discharge. After one of her twelve confinements she evidently had a pelvic abscess—a pint of yellow discharge having come away at a time. She had had three miscarriages; the last confinement was eight years ago, and the last miscarriage nine years ago.

For four months before coming to the hospital she had complained of vaginal pain darting upward through the body. She had also had two operations for the ruptured perineum, both unsuccessful.

The cervix was found to be hard, the os rough and depressed, and there was a hard cartilage-like ring of cervical tissues round the os. The body was forward and large. There was free hemorrhage on the finger and on the sound. The source of the hemorrhage was within the uterus, and dilatation showed it to be from a rough, sprouting, wart-like This settled the diagnosis and treatment. Vaginal hysterectomy was performed about twelve weeks ago, and a few days ago I saw her, stout, active, and enjoying her food better than for years. The recovery was entirely uneventful; the gauze dressing was removed on the fifth day and was then odorless. The perineum was left temporarily: but if her health remains good it will be necessary to repair it, for she has even less control over the bowel than before the operation.

CARCINOMA OF BODY OF UTERUS.

CASE II. M. W., age stated to be forty-eight, looks at least sixty. "Menstrual life was quite regular and normal in every way. Catamenia ceased four years since, but no trouble of any description occurred until seven or eight months ago, when blood was noticed after micturition." Some discharge of dark or bright red color has persisted since, with only occasionally a few days' cessation. Pain was not felt at first, but for the last five months patient has experienced pain at the "lower part of the stomach." Three months ago the discharge was offensive but only continued so for about a week. Latterly patient has lost flesh rapidly. The skin is of a yellowish hue. The urine

was examined before the operation, twice by Dr. Cook, who kindly referred the patient to me, and twice by Mr. Chapman, recently house-surgeon to the hospital, to whom I am indebted for carefully taken notes of the case. Sometimes albumin was present, and sometimes absent.

The cervix uteri was intact, the body felt larger than a man's fist. It was, however, freely movable, and there was no evidence of implication of the broad ligaments or glands.

After the usual preparation by douching, dieting, etc., total extirpation of the uterus was performed by the combined method. The cervix was first loosed from its vaginal attachments, the bladder pushed forward, and a pair of pressure forceps was left attached to the anterior and posterior surfaces of the uterus as guides when detaching the peritoneum from above. The abdominal wall was then divided in the median line, patient being in the Trendelenburg position. The bowels were by this means kept out of sight and kept warm by the abdominal wall and by hot After ligaturing off the broad ligaments and detaching the peritoneum, the uterus was easily removed. During the manipulation of the uterus some of the friable and septic contents were squeezed out into the vagina. Free washing out was performed from above downward, but it is possible that this proved a source of infection. A gauze drain was left in the abdomen and gauze packing inserted into the vagina, after inverting the cut peritoneal edges. On the third and fourth days aperient doses of calomel were given; during the sixth day diarrhea arose ten stools in twenty-four hours. The notes of the house surgeon state—"On the sixth day, pulse 100, intermittent and weak; II P. M., patient feels much better, pulse not intermittent." Seventh day, "Patient had a fairly good night and seemed brighter, until she had a vaginal douche, when she complained of some pain, and soon after became quite collapsed and did not rally." Death took place on the seventh day. The highest pulse rate throughout was 118, the lowest 84; the temperature was always below 100°. An autopsy was made, and the report, kindly furnished by Dr. Vincent Green, is appended in extenso:

M. W. Pan-hysterectomy. Post-mortem, April 13, 1897.

"Marked tympanites. Edges of wound united; red areola round stitch-punctures. On pulling edges of wound apart a clear yellow fluid escaped from the abdominal cavity. A little of this was smeared along surface of agar tube. The abdominal wall contiguous to the wound was separated into two layers. On laying back the upper layer, consisting of skin, fat, and fascia, from the lower layer consisting of peritoneum and rectus muscle, the adjacent surfaces thus separated were found to be covered with a thin layer of greenish-vellow pus (some of this was smeared along the surface of agar tube). The colon was greatly distended, the small intestine less so. Slight injection of mesenteric vessels; bowel, if anything, paler than normal. Immediately above the cæcum was a band stretching across and forming a loop of ascending colon. Other bands fixing the loop down to the abdominal wall laterally. These adhesions were not of recent origin. The right broad ligament lay over the vaginal opening, effectually sealing it. There was no pus or lymph in the pelvis. The ligament tore away very easily, allowing the vaginal opening to gape. A few small glands about the size of a pea and quite soft were felt in the meso-colon. No secondary growths were to be found in liver, kidneys, or spleen. Only abdomen was examined.

"Cultures.—Both serum and pus give the same cultivation. Colonies of the following were examined and seen under the microscope: Staphylococci (pus organism); streptococci (organism of septicæmia); bacilli, probably both saprogenes and pyogenes fœtidus, usually present in septic gangrenous fetid pus."

This patient died from cardiac failure, due to septic poisoning. Her death was unexpected, as she had, even the same morning, appeared bright and talkative. The previous day's diarrhea, due partly to aperients, and probably more to septicæmia, had reduced the patient's strength and

caused even the slight fatigue of a douche to bring about a collapse. It is unusual that death should occur at so late a stage without more evidence of peritonitis, death from pure sepsis usually being before the fifth day, and being accompanied by a much more rapid pulse.

CARCINOMA (EPITHELIOMA) OF CERVIX.

CASE III.—On April 13 last (1897) E. B., aged forty-one. consulted me on account of irregular bleeding. The patient has been a widow about two years; she has had eleven children and five miscarriages. The last child was born two and a half years ago, and the last miscarriage occurred previously to that. Patient has had no illnesses after her confinements or at other times. She lost her husband about two years ago, and about that time and subsequently has had much anxiety and physical strain, as she has a large family of young children on her hands. Up till about Christmas menstruation was irregular (four to seven weeks). but not notably abnormal in any other way. Moderate pain of the nature of "stomach-ache" lasted three or four days at the periods. She has had no inter-menstrual pelvic pain. For two months she has had thin, unirritating, and colorless leucorrhœa. The bowels act naturally; there are some piles which occasionally bleed, general headache, as if the hair were being pulled up, flatulence and anorexia. Sleep, spirits, circulation, etc., all excellent. Patient's statement respecting the hemorrhage was as follows: Since about Christmas menstruation has been too frequent and more profuse than previously. Between the regular periods there have been, since Christmas, irregular bleedings almost daily for a short period at a time; the least exertion sets it off. On examination a large irregular sprouting mass, typically "cauliflower-like," was found to occupy the upper part of the vagina, growing from the cervix. The fornices were free, and the whole uterus was movable. Very gentle examination caused free bleeding. Patient was admitted to the hospital in a few days, and, after ascertaining that the kidneys were healthy, it was decided to remove the uterus by vaginal hysterectomy. With the ready and skillful assistance of Mr. Johnstone this was done five weeks ago. The patient is now out of the hospital, having made an excellent recovery.

The uterus was large, and the growth was found to spring from the anterior lip.

Three days before removing the uterus, the mass itself was ablated by the galvanic *écraseur*, with the object of lessening hemorrhage at the operation, and of enabling more complete asepsis to be maintained. The latter failed, for the cut surface retracted and was not easily accessible to douching.

The temperature rose to 100°, and even at the time of the operation it was raised. This was regarded, however, as an additional indication for immediate complete removal. On the third day diarrhea set in, evidently due to septic absorption. Although the pulse rose there were no rigors and no incontinence of urine or fæces, and no delirium. On the fourth day the pulse was 98 in the evening. The gauze was removed at the end of the third day, and was very fetid. When the diarrhea set in the patient was taking belladonna and mercurius cor. Veratrum alb. was given early on the fourth day at Dr. Moir's suggestion, and this was followed by prompt and material improvement.

Throughout the fourth day carbolic douching every four hours was persisted in, unless sleep prevented. On the fifth a calendula douche was used every six hours.

REMARKS.

Diagnosis.—Case I. was readily determined to be one of cancer. She had had, at the age of about forty-eight or forty-nine, a menopausic interval of nine months. After this, hemorrhage had begun and had continued on and off for six months. It was quite free. This, with the ready bleeding on examination, established the diagnosis of carcinoma, which was confirmed by dilatation of the cervical

canal, and, after removal, by the microscope. In its history this case is typical.

In Case II. the feature of bleeding returning and persisting after the menopause was also present. Although a uterine tumor was present, it did not render doubtful the diagnosis, as the history was clear.

The chief difficulty exists where there co-exist excessive or irregular hemorrhage before the menopause, and a tumor. If the tumor is moderate in size and of fairly uniform surface, diagnosis may be impossible. As I have pointed out elsewhere, the diagnosis under these circumstances, between the uterine myo-fibroma and malignant disease, can only be settled by a previous dilatation and currettage, followed if needed by microscopic examination.

The third case, cervical epithelioma, presented no room for doubt or error; it could be mistaken for nothing else. The warning note given before examination of irregular bleeding coupled with hemorrhage induced by physical exertion, was in itself almost conclusive. The first touch of the soft sprouting mass of cervix, easily bleeding, made probability become certainty.

Cases I. and III. are interesting, as examples of malignant disease developing in women who have borne a large family, and Case III. would confirm the views of those who believe that worry is an exciting cause of cancer. Case II., however, occurred in a single woman.

While sarcoma is usually the cancer of youth, the patient's age cannot here be said to be much guide to diagnosis. In sixteen cases reported by Jessett * the age varied from thirty-two to sixty-three, while in the same series carcinoma is reported as occurring twice in women of thirty-one.

Sarcoma is (if possible) more insidious in its origin, more rapid in its growth, less ready to bleed, and more liable to develop a large tumor than carcinoma. In the case of a largish tumor, say three inches by four inches in diameter, if hemorrhage has been inconsiderable and the discharge

^{*} Brit. Jour. Gynecol., November, 1896.

only stained, the probability is that the disease is sarcoma. A fibro-sarcoma is, however, less rapid than the papillary forms, and often bleeds freely. Pain is less severe in sarcoma unless the growth is very rapid. Infiltration of the surrounding parts is early. The extrusion of brain-like offensive masses is diagnostic only of malignant disease, not of sarcoma; it recurs sooner than carcinoma. After carcinoma (adeno-carcinoma), sarcoma is the most common form of malignant disease, occurring in about twenty per cent. of the cases. Nevertheless, an individual case of sarcoma may be quite indistinguishable except by the microscope; clinical evidence is often of more value in deciding the question of malignancy.

The rarest form is true scirrhus—the cancer of old age. The uterus is small, hard, and tough, with almost cartilaginous feeling, rough, and when curetted bleeding little; progressing slowly. Symptomatically the disproportion between pain and obvious physical change is a leading and striking feature of scirrhus. A thin, acrid, offensive, but not copious discharge is present.

I have occasionally been asked by colleagues, especially at consultations, what are the results proximate and distant of hysterectomy for carcinoma. My personal experience of these cases from the operative point of view is of too short duration to enable me to speak with authority.

Just two years ago I wrote a paper compiled from Continental and American sources, in which the history, technique, result, etc., of vaginal hysterectomy are sketched. As is pointed out there, the early history of vaginal hysterectomy was a triste and somber tale. In a lesser degree the same disappointment occurs in the practice of all individual operators newly undertaking its per formance. Three years ago the operation had not been performed by any English surgeon embracing homeopathy. About that time Dr. Burford led off with a success, since followed by many equally brilliant results. My own early experience was discouraging, for two of my first three cases died. Improved technique and

greater rapidity of operation have brought me better fortune, and from vaginal hysterectomy I have had no fatality for about eighteen months. The mortality among large operators varies from 81/2 to 20 per cent., according to the method in which the statistics are formed, i. e., whether from picked periods and picked cases or from the whole series of an operator's list.

As regards permanent success, in Purcell's experience about forty per cent. recurred sooner or later. In detail

> I patient was alive after 12 years. 3 patients were 3 12 less than 2 years. H

Mr. Jessett's figures as regards immediate results are more favorable than Dr. Purcell's, because he alludes only to a recent series. His recurrences are as follows:

> I patient no recurrence after 4 years. 6 patients 5 I 3 when last seen. 10

In 6 cases recurrence took place in six months.

" I " I year. " 9 " early.

M. Richelot gives a summary of twenty-eight cases which recovered from the operation of vaginal hysterectomy for cancer, and remained under observation.

Of these there was recurrence in eleven cases after periods of from 51/2 years to 3 months. Of the remainder

3 had not recurred in periods of from 4 to 8 years. 3

after from 2 to 3 years. 3

after from 2 years to 2 months.

German surgeons state that the percentage of cures, namely, those cases in which the disease does not recur in three years, is from 35 to 45 per cent. Fabri of Modena reports 16.6 per cent. cured.

DR. BURFORD said that only twenty years ago not only was surgery quite incompetent to deal with such cases as the author had mentioned, but their very existence was denied. The best record of statistics in the world's history with which he was acquainted with regard to the extirpation of the carcinomatous uterus were those of Leopold. Many of the details, which had been reproduced in the Manchester Medical Chronicle, were simply surprising and made a great impression. The longer experience the operator had, and the more discrimination he evidenced in the selection of cases, not only the more immediately satisfactory was the result but the longer time did cases go without recurrence. With regard to diagnosis he had had some very varied experiences. He had come to place more trust in the clinical indications of malignant growth than in microscopical results. The opinion of all operators, little and big, at the British Gynecological Society, was that the clinical observations were more important than the microscopic. An American said that after an operation the microscopist had reported that he could find no trace of malignant disease, but the patient died six months later of recurrence. He referred to a case in which a specimen of material removed had been submitted to Mr. Johnstone, who reported that the patient had sarcoma. As the friends were anxious that a confirmatory opinion should be obtained another consultant was called in, who brushed aside the microscope and went on the physical diagnosis alone, and decided that the patient should have three months' grace with a view of seeing whether local treatment would not suffice; but he (Dr. Burford) entirely agreed with Mr. Johnstone, and they still awaited after-results, feeling pretty confident that the pathological growth would justify the position they had taken. Early in the year a woman had come to him with symptoms of menorrhagia, and he imagined it was an ordinary case of fungus endometritis, but on curetting, one particular spot indicated a different condition of things—he scraped away till he nearly got into the peritoneal cavity. A specimen of one part of the uterus submitted to Mr. Johnstone was declared to have no evidence of malignancy, but a specimen of another part showed sarcoma of the uterus commencing in the gland ducts. The uterus was removed, and a sarcomatous ulcer about the size of half-a-crown was found, justifying the operation and also the diagnosis. With regard to fibroid sarcoma, his experience was that it had altered from what it was some years ago. There were certain cases which for a number of years were fibroid, which ultimately developed, like a "bolt from the blue," symptoms of sarcoma. He held that to be one of the indications for the removal of fibromata at a period when they were likely to give trouble, particularly if the patient entered into the married state. A patient came to him some months ago with every symptom of fibroid of the uterus, but she scoffed at his suggestion of an operation. She died a few days ago from sarcoma of the uterus. The symptoms had developed during the last three or four months. She had married in the interim, and the experience of every gynecologist was to the effect that marriage late in life, in a lady who was the known possessor of a fibroid tumor, was exceedingly likely under unfavorable conditions to lead to the development of malignant disease.

Dr. Madden mentioned the case of a lady who had serious uterine symptoms, diagnosed by Dr. Burford as malignant disease, in which vaginal hysterectomy was suggested. A second opinion was insisted upon and an eminent allopathic surgeon was called He entirely demurred and thought it was nothing more than ordinary sub-involution and chronic metritis, and suggested the usual series of local treatments common in such cases. den insisted on a third opinion, which was obtained. The third specialist suggested that the uterus should be dilated and curetted. This was done, and specimens of the resultant curetting were submitted to the Clinical Research Association and to Mr. Johnstone. Mr. Johnstone reported evidence of malignant disease, but the Clinical Research Association said they could find nothing but evidence of recent pregnancy (which was perfectly perceptible to the naked eye). On this second experience of divided authority, specimens were sent to the highest authority possible—Professor Hamilton of Aberdeen-and his report was that it was undoubtedly a case of malignant disease. At last, after wasting two

valuable months, the uterus was removed by vaginal hysterectomy, and the lady made a very satisfactory recovery.

DR. NEATBY, in reply, said he agreed with Dr. Burford on the way in which uterine fibromata took on active changes in married life. He had placed one such case on record himself in the London Homeopathic Hospital Reports, and had seen at least one other subsequently. It was a very important point when they had to deal with cases of that kind, when tumors which had hitherto been stationary came before them with sudden and unexpected enlargements.

DYSMENORRHEA.

By John Kent Sanders, A. M., M. D.

NOTWITHSTANDING the challenge to the wisdom and skill of the profession since woman became the victim of disease there still remains a malady, universally regarded as curable, from the terrible suffering of which she has not yet obtained the immunity to which she is surely entitled, and which the profession is ever promising her. This malady is the so-called dysmenorrhea, which may assail woman from the beginning to the termination of menstrual life.

Explanation of this intractability under the skill which has been bestowed upon it probably largely, if not chiefly, rests upon the erroneous classification of the forms in which it presents in different cases, and the resulting mistaken views of its ætiology and pathology.

The aim of this brief paper is to awaken discussion and invite attention to a more correct classification, and more accurate opinions as to its ætiology and pathology, with a view to the attainment of a more successful surgical and therapeutic result.

A woman may feel unwell at the menstrual period and yet be perfectly normal; that is to say, she may experience a general feeling of malaise; a few ill-defined pains, which may be referred to the loins, back, or the abdomen, and

there are usually present a peevishness and irritability of temper to a greater or less extent. If there is absolute pain immediately preceding or during menstruation, it is called dysmenorrhea. To draw the line absolutely between what might be considered the discomfort of a normal menstrual period and a mild dysmenorrhea is sometimes difficult. A woman who seems to be in the best of health, and is so, may have such a nervous organization that a minimum of pain might be considered by her as considerable, and then again, as affecting a plethoric or lymphatic individual, the same amount of pain might be considered as a mere nothing. In the majority of text-books on gynecology different varieties of dysmenorrhea have been so classified and divided and subdivided that we usually find five now given, as follows: 1st, Neuralgic; 2d, Congestive; 3d, Mechanical; 4th, Ovarian; 5th, Membranous; some divisions being made on an anatomical basis, as, for example, "ovarian and membranous," which anatomically signifies uterine. Then again, a division on a pathological basis of "neuralgic and congestive," and still another in this same classification depending on its varying ætiology, thus presenting an unscientific and unnecessarily complicated classification.

The classification adopted by Pozzi, in his admirable work on gynecology, although he is decidedly confusing in his classifications of other troubles, groups all dysmenorrhea under two heads, according to the time the pain is present. "First, during the ovarian-tubal period (ripening of the follicle); in other words, dysmenorrhea of Ovarian Origin, and second, during the uterine period (of expulsion of menstrual blood); in other words, dysmenorrhea of Uterine Origin."

I respectfully submit that his first division would better be subdivided and designated respectively ovarian and tubal, so that the classifications be made to stand, 1st, ovarian; 2d, tubal; 3d, uterine. This division covers the ætiology of every manifestation of the malady and all the pathological conditions waiting on its progression. I will discuss the subject under this classification and in this order.

rian origin is more frequently due to immediate or remote effects of pelvic inflammation. Structural changes in the ovary itself, due to septic or specific infection through the fallopian tube, are more common than one would be led to think from the old text-books on the subject, but undoubtedly these changes, with deposit of fibrous connective tissue, have a great deal to do with the development of this type of dysmenorrhea.

Varicose conditions of the pampiniform plexus of the ovary can account in part for many cases which were formerly classified as neuralgic; the added turgescence and dilation due to the menstrual congestion producing pressure on the ovarian nerve supply.

Displacements of the ovary are also a cause, where the ovary is carried out of position either by adhesions, result of pelvic inflammation, or from a relaxed condition of the pelvic floor.

Adhesions of the ovary to a portion of the contents of the abdominal cavity sometimes occur as a result of inflammation in the abdominal cavity, and in that way may be productive of dysmenorrhea; as, for example, the attachment of an inflamed appendix vermiformis, or a Meckel's diverticulum, or a tumor of the abdomen, or other displaced and inflamed contents of the abdomen.

Tumors of the ovary, such as ovarian cysts, sarcoma, or carcinomatous involvement of the ovary, of course may be a cause of this form of dysmenorrhea.

2d. Tubal Dysmenorrhea.—Where we find decided changes of the structure of the lining membrane of the fallopian tubes that there should be obstructive adhesions is self-evident, and even when there is a catarrhal condition simply, the added congestion of the menstrual period coming on undoubtedly affects the mucus that is secreted in greater quantity, so that it also acts obstructively. When these same conditions are transferred to the fimbriated ex-

tremity, it requires more than a normal pressure in the ruptured graafian follicle.

Septic or specific inflammation of the tubes, in any grade of progression, may be productive of pain during the aggravation of the menstrual congestion.

Then again the pelvic inflammations that have caused formation of fluid or deposit of inflammatory exudates, in the broad ligament or away from it, may cause pressure on the tube, or tubes, or a deviation in the direct channel to such an extent as to occasion obstruction, not absolute always, but sufficient to cause a great deal of pain before the uterus is affected.

Then again malpositions of the uterus may affect the line of connection between the ovary and the uterine cavity to such an extent as to produce this variety of dysmenorrhea, as also in the same mechanical manner as displacement of the ovary.

Tumors of the uterus, or tumors in connection with the abdominal contents, may produce obstructive pressure on the tubes.

3d. Uterine Dysmenorrhea.—Dysmenorrhea of uterine origin may have a variety of causes, but from whatever cause the suffering is due to the labor-like efforts of the uterus to discharge its contents. The majority doubtless depend on some pathological condition of the endometrium. Simple catarrhal endometritis is seldom the cause except in cases where there is a very small os, or in cases where there is an extreme degree of flexion. There may be also a low grade of catarrhal endometritis which is aggravated materially by a depletion of the system; it may be materially aggravated by congestion in the portal circulation; it may be materially aggravated by deficient alimentation due to underfeeding or overfeeding, or may be decidedly aggravated from lack of proper rest and sleep. and also by a constant drain on the nervous system from social dissipation or overwork.

Simple catarrhal endometritis may be caused, as well as aggravated, by the first accomplishment of coitus, or later

excessive sexual indulgence. These aggravations of simple catarrhal endometritis are an easy explanation of the type of so-called neuralgic dysmenorrhea which occurs in females with a previous history free from any menstrual pain or lack of pronounced symptoms of endometritic trouble.

Septic infection produces the higher grades of endometritis except where infection is specific.

The term neuralgia has been used for pain in so many different localities where a deeper pathological condition has been discovered to be the foundation for this symptom, that it is with greater hesitancy that we should use the term neuralgic dysmenorrhea, now that we are approaching a clearer understanding of the changes that the tissues and organs of the female pelvis may undergo. There is no doubt but what in very exceptional cases there is pain in connection with the menstruation that is materially aggravated by a rheumatic or gouty diathesis. The vast majority of so-called neuralgic cases are of young women who are anæmic, or who are below par in nerve tone from some unusual demand on the nervous system. These cases cannot truly be classified as suffering from neuralgia, but almost in every case it will be found that there is a greater or less degree of catarrhal congestion of the cervix and body of the uterus.

Specific infection is so rarely limited to the vagina, and when once in the fundus uteriso often involves the tubes, that its factor as a producer of uterine suffering is limited to a short period.

As a result of endometritis we may have cystic degeneration of the endometrium with a formation of one or more cysts. This may go on to the formation of a mucous polypus on the inside of or on the body of the womb, creating a ball and socket valve, so to speak, over the cervix that may prove a source of obstruction and consequent suffering by the pressure above the polypus of the menstrual fluid. Endometritis may go on to such a severe grade of inflammation as to cause a morbid proliferation of cell and

fibrous exudate, and we may have a membrane formed that has as its base the submucosa, closely simulating the decidua of the gestative state; in other words the so-called "membranous dysmenorrhea." It may be a gradual development from the simple catarrhal endometritis, and should not form the foundation for a classification of the disease of which we are speaking.

There is a possible cause which may be mentioned: an arrest in development,--" infantile uteri,"-with a full development of the uterine appendages. The "pinhole os," which is so often given as a cause for dysmenorrhea, is seldom the cause alone. There are a great many normal uteri that will not admit an ordinary probe without discomfort. When we remember that at the most, a normal flow does not amount to more than two fluid ounces in twenty-four hours, and that will hardly average two-thirds of a drop a minute, it is easy to understand how that amount could come through an extremely small canal without any difficulty. Of course, if the "pinhole os" is accompanied by any grade of inflammation of the endometrium above that would cause a clotting of the blood, or a very great increase in its amount, then the "pinhole os" may become effective in the production of pain, but the "pinhole os" per se causes it rarely.

Different versions and flexions of the uterus also, very seldom occurring independent of some pathological condition of the endometrium, may be the immediate cause of dysmenorrhea. These displacements may be produced by tumors of the uterus, tubes, or ovary, and by tumors of the abdominal cavity.

Stenosis of the cervix, congenital or the result of acute traumatic inflammation, may be a cause; also stenosis of vagina.

Tumors produce it; even fibroids of medium size and long pedicle may act in the same manner as a polypus and make a valve. Carcinoma of the cervix, or body, may cause a rigidity which produces great pain at menstruation.

Subinvolution resulting from labor or abortion is a fac-

tor; in these cases a gouty or rheumatic diathesis would tend to increase the suffering.

Tuberculosis of the genital tract, where it affects the endometrium and the body of the uterus itself, is a cause of dysmenorrhea that is often unrecognized.

It is to be hoped a clearer conception of the varied causes of this trouble, and the broadened view to which this brief presentation may call attention, will not fail to enlarge the range alike of its regimenal, therapeutic, and surgical management, and this enlargement of our helpful and curative resources will accomplish the aim and scope of the paper support MEDIO

THE SURGICAL TREATMENT OF TUBERCULOSIS.*

WM. DAVID RAB M.D.

Professor of Surgery, Kansas City Homeopathic Medical College.

CONSUMPTION, scrofula, tuberculosis; these are U synonyms for the same malady. The bacteriologists teach us that the tubercular bacillus is present everywhere, in every tissue of the body. It awaits merely a suitable nidus in which to spring into activity. If this doctrine is true, it will easily elucidate many dark problems connected with the clinical study of tuberculosis. We are also taught that carbolic acid is a sure germicide for this form of infection. In order that the drug may destroy the germ, however, it is necessary that they shall come into contact. A large majority of cases of consumption or tuberculosis are those in which the disease is internal, or which affect the internal viscera of the body, as the lungs, liver, intestines, etc. Other forms of this affection are seen in hip-joint disease, caries and necrosis of the bones, and suppuration of the joints. It is also a well-known fact that carbolic acid is an active, virulent poison. Taken into the blood in material quantities it shows first its toxic action upon the

^{*} Read before Homeopathic Medical Society of Kansas, 1897.

functions of the kidneys, rapidly inducing uræmia, coma, and death. The surgical treatment, therefore, of tuberculosis brings to notice these several facts. It is the business of the surgeon to meet the conditions for the destruction of the germ without, at the same time, destroying the patient. In those cases in which it is possible to apply the drug directly to the diseased tissues the problem is fairly easy. In cases of tuberculosis of the skin, tubercular degeneration of the joints and bones and other tissues which are easily exposed, the application of the remedy is readily made and its action is prompt and satisfactory. such cases it is advisable to use the saturated solution of the chemically pure carbolic acid. The infected area should be effectively curetted under anæsthesia and the drug freely applied to the exposed surfaces. Antiseptic dressings should then follow. It is necessary, in order to reach prompt results, that the application of the acid should be repeated daily until the wound is fully closed by granulation. After the first application of the acid, the subsequent treatment is not so painful as might be supposed. Carbolic acid, in addition to being a caustic, is also anæsthetic, so that the pain continues but a brief period after the application of the drug. In those cases in which the patient is extremely sensitive, it may be advisable to apply to the surface to be treated first a four per cent. solution of cocaine in order to deaden the sensitiveness, after which carbolic acid is freely applied with sponges of gauze.

OVARIOTOMY AT THE SEVENTH MONTH OF PREG-NANCY: RECOVERY COMPLICATED BY INSOMNIA AND MENTAL ABERRATIONS, AND THEIR PROMPT SUBSIDENCE UNDER ACTÆA.

By George Burford, M. B.,

Physician for Diseases of Women to the London Homeopathic Hospital.

THE pregnant state is curiously tolerant of ovariotomy, and fortunate it is that this is so, for the additional risks pregnancy brings to ovarian tumors are various and grave. Strangulation of the cyst, from torsion of the pedicle; rupture of the cyst, and even of the uterus; and, specially with the smaller cysts, the most serious hindrances to delivery are to be apprehended. All these are real risks and have actually occurred in practice, and therefore the conjunction of pregnancy with ovarian cystic disease is of grave import.

Not only single ovariotomy, but even double ovariotomy may be and has been performed, after which pregnancy has safely gone on to term. I have before me a list of cases in which this issue, happy alike to mother and child, has eventuated; but it is essential in the case of double ovarian cyst that the operation be performed in the early months of pregnancy. Equally desirable is early interference when the cyst is single; but that in this case a satisfactory issue may accrue both to the ovariotomy and the pregnancy, if operation be undertaken later, the ensuing case will show.

In the earlier part of this year, Dr. McKilliam of Blackheath was called to a lady seven months advanced in pregnancy, but in whom he diagnosed also an ovarian cyst of some dimensions. Apart from the distress due to the bulk of the mass, the patient was victimized with troublesome vomiting, which of late had become intractable. Nutrition was seriously impaired; discomfort was considerable, and the immediate outlook was the reverse of satisfactory. Dr. Joseph Kidd saw the case in consultation; the verdict

was for an immediate ovariotomy, which was delegated to me to perform.

In May I performed the operation, removing a large ovarian cyst, arising from the left ovary. The uterus was normal to the date of pregnancy; the veins in the pedicle were large and numerous. The operation proceeded without complication; and for the first two days the convalescence was uneventful.

On and after the third day the mental condition of the patient underwent a noticeable change. Her conversation and replies were incoherent and disjointed; during the day a fatuous smile accompanied articulation, and her mental state seemed in general that of hebetude. There was also a persistent tendency to push down the bedclothes. At night the tout ensemble was that of irritability; she would repeatedly make efforts to get out of bed; and sleeplessness was pronounced. Belladonna was given at short intervals during the day, with gelsemium on the third night, aconite 3 on the fourth night, and a full dose of morphia on the fifth night. Of these remedies, the morphia only secured any sleep, and that merely for a short period of two hours.

In other respects the after-progress of the ovariotomy was normal, save and except a slight but recurring evening rise in temperature. As the sleeplessness seemed intractable, and the mental condition showed no signs of improvement, I asked Dr. McKilliam to meet me in consultation, that his knowledge of the patient's idiosyncrasies should be turned to account. At consultation he suggested the administration of actæa Ix, four times daily, which was accordingly prescribed.

The result was almost dramatic, the first night ensuing the patient had four hours of continuous sleep, the next night six or seven hours, and thereafter the insomnia vanished. Contemporaneous with the improved capacity for sleep came general betterment in the mental condition, and, four or five days after the first administration of actæa, the convalescence became and continued smooth and easy, the mental symptoms vanishing.

During the period of stress there was no tendency to miscarriage; and the pregnancy proceeded without interruption to term. At an easy and uncomplicated labor the lady was delivered of a daughter, and Dr. McKilliam states that the puerperium was, at the labor, without impediment. The child was well developed and healthy.

I have seen from time to time conditions of mental perturbation yield to the charm of homeopathic remedies, but this case, in my experience, was unique in the promptitude with which the mental cloud disappeared under the use of actæa. The result was equally striking to the friends, who, with ourselves, were much disquieted at the incidence of the psychical aberration.

A CASE OF RETROVERSION OF THE GRAVID UTERUS, TREATED BY FLUID PRESSURE.

By ALEX. H. CROUCHER, M. D., EDIN.

RETROVERSION of the gravid uterus is an occurrence in the course of pregnancy which was known in the sixteenth century, and was referred to in 1535 by Œtius Adimenus. Various writers have written on the subject in the eighteenth century; Dr. William Hunter read a paper on it before the Medical Society in 1770, and many cases have been described since. Various causes have been attributed. At one time it was thought that it was most generally produced by some accident, such as a fall, which dislocated a uterus previously in a normal position; over-distention of the bladder was also considered to have an important effect in producing it, by pressing the uterus backward and downward.

It is now commonly admitted, that though the above mentioned may produce it, in most cases it depends on pregnancy having occurred in a uterus previously retroflexed or retroverted. The late Dr. Tyler Smith pointed this out, and this view has been concurred in by others.

In the case about to be related, the immediate cause was apparently a sudden jerk; the uterus may have been partially retroverted, but the jerk at any rate seems to have brought on acute symptoms. As a rule, a backwardly displaced uterus, after pregnancy has occurred, as it enlarges straightens itself, and rises in the abdominal cavity without causing pathological symptoms.

Dr. E. M. Hale, in his book on "Diseases of Women," relates many cases where a retroverted condition of the pregnant uterus seemed to have been the cause of serious vomiting.

The continued enlargement of the displaced gravid uterus in such a cramped position in the pelvic cavity may produce an abortion, or there may occur pressure on the urethra and rectum; then trouble occurs.

The symptoms are dysuria, and probably retention of urine with "over-flow," simulating incontinence; the patient thinks she has passed too much water, and the distended bladder is not noticed. Sometimes the obstruction to the flow of urine causes ædema of the legs. Obstinate constipation with tenesmus are present, pelvic pain, pressure, and bearing down come on. Spontaneous relief occasionally occurs, but if the condition goes on, cystitis and laceration of the bladder walls may occur, followed by fatal peritonitis, vide Lancet, March, 1890. Uræmia is another complication. The uterus itself may suffer, its walls slough, abscesses form, fistulous communications in vagina and bladder occur, with a probable fatal ending from exhaustion and blood poisoning. I will now relate the history of a case which was relieved, "tuto, cito, et jucunde," by the pressure of a Barnes' bag introduced into the vagina and distended with water.

On July 23 of this year a district nurse came to me with the request that Mrs. S., æt. thirty-four, should be admitted into the Leaf Homeopathic Cottage Hospital; her statement was that the doctor in attendance had said that the woman, who was pregnant, had a fall a fortnight before, causing an internal hemorrhage, and that now a large abscess had formed.

The patient was admitted about 4 P. M. that day, and was seen at 5 P. M. On interrogation, patient complained that she was suffering great pain in the lower part of the back and in the abdomen, that there was difficulty in micturition and defecation. The patient stated that she was four months pregnant, had had three children, the youngest being two years and a half old, and that she had had no miscarriages. She dated the commencement of her trouble from July 10; on that day she was getting out of an omnibus and fell backward onto the step, but did not lose her feet. She rebounded forward and would have fallen had not a bystander caught her. On inspection the lower half of the abdomen was greatly distended; this on palpation was found to be a fluctuating swelling, reaching to the Mrs. S. stated that her doctor had visited her umbilicus. constantly since the accident.

On examining p. v. it was difficult for the examining finger to reach the os uteri, which was high up and to the front, jammed against the pubic arch.

Occupying the posterior and lateral fornices, and pressing down into the vagina, was a large, rather soft swelling. A soft rubber catheter was introduced into the bladder and forty-four ounces of urine were drawn off; the urine was thick, had a stale odor, and on further examination was found to be loaded with albumin. Bimanual examination now showed that the case was one of retroversion of the gravid uterus. The patient was put in the genupectoral position and reposition attempted, with no result, but much pain to the patient. At 8 P. M. a Barnes' bag was introduced into the vagina and fully distended with water; next morning the patient was free from pain, and the uterus was out of the pelvis in its natural position. The catheter was used night and morning, and the bladder washed out with boroglyceride solution.

The future progress of the case was uneventful; the

urine became free from albumin and the bladder resumed its function, and the patient was discharged on August 26.

After writing these notes, I was looking over a book entitled "A Collection of Cases and Observations in Midwifery," by William Smellie, M. D., vol. ii., the third edition, London, 1764, and found described a typical case of retroversion of the gravid uterus. It may be interesting to quote it in its entirety.

He says: "I was lately called to a woman in the fifth month, and felt the fundus uteri pressed down backward to the lower part of the vagina, the os uteri being forward and above the inside of the left groin; the neck and under part of the bladder were so pressed that the patient had not urined for several days. The vesica was stretched up to the scrobiculus cordis, and a fluctuation was felt as in an ascites. The male catheter was used, because the other was too short, and emptied a great quantity of urine, so that the distention of the abdomen considerably diminished. Next day after the same operation she miscarried; consequently the obstruction was removed, but being greatly emaciated by want of nourishment she was in two or three days carried off by a diarrhea."



THE RELATION OF THE SPECIALIST TO THE GENERAL PRACTITIONER.*

By Geo. R. Southwick, M. D.

THERE has been a generally recognized classification of the medical profession for many years into two broad divisions—that of medicine and that of surgery. In England the distinction has been very pronounced, separate degrees being given for each. The term "Doctor" in England applies strictly to the prescriber of drugs. The surgeon's title is "Mr.," and the Fellow of the Royal College of Surgeons is more than likely to correct you courteously if you call him "Doctor." The distinction of the surgeon from the physician is sometimes curiously made. It was the custom in Dublin for many years, and may be at the present time, for the surgeon to have his name on a simple door plate, as Mr. Jones for example, but the door invariably was painted white, which, by general acceptance of custom, indicated the particular calling of Mr. Jones.

The more practical American, however, has observed the importance of the specialist from another point of view, i. e., as one who must be an adept in the treatment of a special group of diseases by all methods, medical, surgical, or mechanical. In other words, American genius adapts all methods to cure a given group of cases. It does not endeavor to force the disease to adapt itself to any one method as that of medicine, surgery, or mechanics, but all must work together for the good of the patient.

The development of specialty work in general medicine has been due to public demand, which in like manner determines the affairs of business. The time is still in the memory of man when the practice of treating the diseases of women was considered beneath the dignity of a well-regulated practice and closely akin to quackery. The same thing in comparatively recent years might be said of genito-urinary or rectal diseases, particularly in the West,

^{*} Read before the Massachusetts Surgical and Gynecological Society.

where practitioners in questionable repute have announced themselves as rectal specialists. Public opinion has demanded better qualified men, and to-day these and many other branches of medicine and surgery occupy an honored position in response to public opinion. The public has a right to require exceptional skill from a specialist. The sick man or woman desires, first of all, to get well. The family physician is summoned. In a large majority of cases the patient makes a happy recovery. The patient trusts implicitly the physician, and the latter is honor bound to act for the welfare of the former. If he can benefit the patient by a consultation, it is his duty to obtain one, and that not a stereotyped individual for all cases; not a particular and personal friend to confirm the diagnosis and treatment, but to discharge honorably the duty imposed on him by the confidence of his patient.

The fact often is overlooked that the various specialties gradually are becoming more limited. The higher medical education qualifies the general practitioner to do well much of the work which formerly required special aid. There are not a few progressive practitioners who some years ago could not have been relied on to recognize a cataract, to diagnose ordinary inflammation of or about the tympanic membrane, or to use a vaginal speculum intelligently. Thanks to the post-graduate schools and to diligent study of carefully written literature, these same practitioners treat successfully nearly all their cases.

The success as a school with which we prescribe for many diseases requiring in other schools local or surgical treatment has not been sufficiently recognized in reference to its influence in handicapping the growth of the various specialties. The general practitioner says he can prescribe as well as the specialist. This is true in a large percentage of cases, but failure ought not necessarily to preclude a prescription from someone of wider experience in treating such diseases.

The concentration of study on various departments of

medicine or surgery by those who have been trained thoroughly, and with ample opportunities for observation. has been of great advantage. Nearly all important progress has been obtained through special study, and the general practitioner has received the benefit. The oculist has explained the cause of many a headache which baffled the family doctor. The nasal specialist has revealed the secret of many reflexes. It is the aurist who has done so much in recent years to relieve deafness. Thanks to the orthopedic surgeon, the general practitioner undertakes the treatment of hip disease or spine curvature in the young with much greater confidence than formerly. Progress in obstetrics has been obtained through the obstetrician rather than the physician. Progress in gynecology has been uniformly through the gynecologist rather than the general practitioner of surgery. The general surgeon has fought his way to fame and advanced his art through the practice of general surgery rather than its specialties, which often are in close touch with medicine.

Self-styled specialists are numerous—unworthy of the name, and utterly unqualified for the delicate. judicious. and reliable treatment which the name implies. The general practitioner has a right to expect, and the public to demand, a high and unusual degree of skill from a properly qualified specialist. Such an one must be thoroughly equipped for the treatment of rare and difficult cases. Personal experience must be large, and aided by extensive knowledge of contemporary opinions and work of his confrères at home and abroad. Medicine, surgery, and mechanics (physics) must all contribute to make the work of the specialist more perfect and his opinion unbiased by any ism or habit of practice. It is too often forgotten that surgery, like medicine, has its specialties and plays an important part in the work of the true specialist. This is the American idea of a trained specialist. It depends on our general practitioners to determine whether such specialists are desired among us as among our neighbors of a different faith. So long as a physician is a mere man of physic

for all diseases, and the surgeon a man with a scalpel for all cases where physic fails, and the general practitioner summons one or the other to his aid without regard to special qualifications, just so long will he retard the real progress of special skill in medicine.

Let the general practitioner prepare to care for all cases which may come; but if here and there aid must be had, let him select from his colleagues, and entirely apart from personal consideration, some specialist, as viewed from an all-round American standpoint, qualified for that particular case to give the greatest possible benefit to his patient. Let his ear cases call on the aurist, his eye cases go to the oculist, nose and throat cases to the corresponding specialist, orthopedic cases to the orthopedic physician; rectal cases to the rectal specialist; obstetric consultations to the obstetrician, and both the medical and surgical treatment of the female genital organs should go to the gynecologist.

The general practitioner puts the specialist in an unpleasant situation when he tells the patient his own diagnosis. Sometimes he is mistaken, and the specialist may offend by disagreeing with the previous opinion. The Golden Rule may require more faithful practice, but the specialist is too often charged with stealing patients and families. He knows too well that a successful special practice cannot be built up in this manner. There is nothing more fatal to the practice of medicine in its highest and best sense than that hydra-headed monster, professional jealousy.

APPLICATION OF THE FORCEPS.*

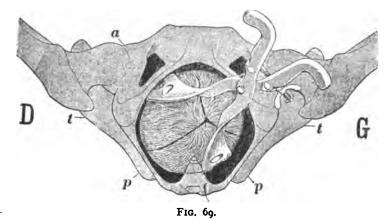
TRANSLATION BY B. F. UNDERWOOD, M. D.

(Continued from p. 569, November, 1897.)

EXTRACTION.

WHAT remains to be done with the forceps, to complete accouchement? The descent of the head is to be completed, rotation provoked, the head brought through the inferior strait into the soft pelvis and finally outside of the vulva.

a. Accomplishing the descent. By traction made in the direction of the axis of the blades and in the known axis of the pelvis, moderate but sustained traction, the head is to



be brought upon the pelvian plane, if it is not already there. If there, as we have supposed, it is brought to the entrance of the inferior strait, until the resistance can be plainly felt and the distention of the perineum can be seen. It has already been shown how this should be done with the forceps of Levret and the forceps of Tarnier.

b. Rotation. When, and only when, the descent has been completed and the perineum has been distended by the

^{*} From the French of Professor Farabeuf and Dr. Varnier.

head, traction being maintained, a slight movement of rotation will be given to the forceps, if it does not occur of itself, to bring the neck of the child behind the pubis, the occiput under the symphysis. The right blade forward will come directly to the right, the left blade backward will go directly to the left. Rotation will have been accomplished when the handle of the right blade will have passed to the left, the handle of the left blade to the right, the crochets being directed transversely.

This movement of rotation of the blades, and consequently of the head which they grasp, is obtained, as has been already explained, by imparting, through the fingers, to the extremities of the handles, a circumduction about

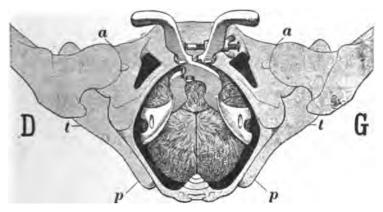


FIG. 70.

the longitudinal axis of the head parallel to that of the blades. In the present case, occipito-right-anterior position, the hooks, starting from the same right anterior attitude, describe an arc of 45° and stop on the median plane in the public attitude corresponding to the occipito-public position the head has assumed. Figures 67 and 70.

c and d. Engagement in the soft pelvis and disengagement outside of the vulva. As in the case of the direct application, which has been described, it remains to engage the head in the soft basin making at first traction in nearly

a horizontal direction, then to pass the perineum and through the vulva, progressively making the traction in an upward direction.

Figure 69. Vertex at the inferior strait, in occipito-right anterior position. The forceps have been applied, articulated, and locked. The point of departure of the rotation of 45° which will bring the occiput and the forceps directly in front as shown in figure 70.

Figure 70. Vertex at the inferior strait in anterior direct position, result of the rotation of 45° from the position shown in figure 69.

CLINICAL SIGNIFICANCE OF BLOOD-STAINED LEU-CORRHŒA.*

By Edwin A. Neatby, M. D.,

Assistant Physician for Diseases of Women to the London Homeopathic Hospital.

T does not require a very lengthy experience of disease to discover that many cases decline to fit themselves into the limits presented by text-books, or to submit to the rigid classification of these authorities. If this be true in general medicine, it becomes additionally noticeable if any special line of work is pursued, and a considerable number of the same class of cases are passed in review. The lesson has to be learned, perhaps, that a given symptom, supposed to be confined to a particular disease, is not only often absent from that disease but crops up in several others from time to time. Individual pathognomonic symptoms thus diminish in importance, and as the "ancient landmarks" disappear, a feeling of uncertainty and con fusion replaces the sense of security begotten of blind and undeserved confidence. Something has to be unlearned before the new truth can be discovered.

With respect to the symptom forming the subject of this short article, the opinion has forced itself upon me that it

^{*} Published also in the Monthly Homeopathic Review.

has been unduly exalted by some medical practitioners as a sign pathognomonic of a certain serious disease, while by others its significance and importance has been wholly and disastrously overlooked. I allude, of course, to blood-stained leucorrhæa as a sign of uterine cancer. Now observation shows that neither extreme view is justified by facts—extreme views seldom are. In other words, such discharge is neither confined to cases of carcinoma uteri, nor always present in such cases.

A. So well recognized a sign of malignant disease of the genital organs is colored and offensive leucorrhæa, that it is unnecessary to occupy more than brief space in proving it. The appended case furnishes a melancholy example of the danger of ignoring the warning raised by its presence.

CASE I. S. D., widow, æt. sixty-seven, came to the London Homeopathic Hospital in 1804, stating that she had suffered for two years from yellow, thick, vaginal leucorrhœa. For three months the discharge has been reddish or brownish; it was occasionally, but not always, offensive. She had been treated for some time outside for senile endometritis. The uterus was small and movable. the vagina atrophic, and except the character of the discharge—blood-stained, offensive, varying in quantity, color, and odor-nothing obvious was noticed to contradict the diagnosis mentioned. Nevertheless, the case was thought to be one of early carcinoma of the body of the uterus: arrangements were accordingly made to admit her into hospital for further investigation and treatment. At this time she took fright, and absented herself for about a year. When she presented herself again, her changed appearance at a glance confirmed our previous suspicions. The uterus was found to be enlarged, hard, immovable, and surrounded by indurated new deposit. It was too late to operate. This patient sacrificed her life to the fear of an operation.

CASE II. To illustrate the converse—namely, carcinoma without the leading symptom under discussion—I may adduce the case of Mrs. W., æt. fifty, sent to me by a medical friend. Until six weeks before her visit to me she

had been "regular" every four weeks. Her last period had continued fourteen days, and after a short interval recommenced and lasted four weeks. There was no odor and only slight intermenstrual white unirritating leucorrhœa. On examination, the cervix was found transformed into a hard, large, nodular, readily bleeding mass, two inches in diameter; the uterus was fixed, or nearly so, through implication of the vaginal wall and broad ligaments. To such a hopeless stage may uterine carcinoma advance without any of the typical discharge, or, indeed, any sign or symptom calling the patient's attention seriously to her health.

B. Connected by suspicion with cancer of the womb, there not seldom present themselves another class of cases—those due to the imperfect expulsion from the uterus of the products of conception—most usually after a miscarriage.

An interesting example of this kind occurred in the person of

CASE III. Mrs. S., æt. thirty-six, married sixteen years, had had four miscarriages. She came to see me in March, 1895, complaining of more or less constant reddish-brown (and sometimes offensive) discharge since the previous November. If the brown discharge ceased it was replaced by a yellowish and excoriating discharge. She was well in her general health, and indeed was gaining flesh. had had three somewhat similar attacks. The first, ten years previously, without known cause, lasting from January to August, was treated by a private practitioner for miscarriage, but she was told at a hospital that this had not occurred. The second attack lasted from August to December, 3½ years previously, and followed a miscarriage. The third attack lasted three months, and the fourth, for which she consulted me, followed a delay of two weeks in the appearance of the catamenia. A month's medicinal treatment, together with douching, etc., produced no improvement, and the uterus was then curetted. After the operation there were two somewhat abnormal periods, but since then all unusual discharge has ceased. The microscopic examination of the scrapings revealed chorionic villi and placental tissue.

C. Endometritis, I think, must be accepted as another condition capable of manifesting, as one of its objective symptoms, a colored discharge.

CASE IV. Mrs. M., æt. forty-seven, had attended one of the special hospitals and been told she had cancer. At the end of 1894 she came to my clinique for menorrhagia and dirty, unpleasant vaginal discharge. The patient had had no family, and she was still regular. The cervix was normal in appearance and the body was not enlarged, fixed or tender. The character of the "leucorrhœa" had probably formed the ground of the opinion given to her else-Early in 1895 I thoroughly curetted the uterus and removed a small piece of the cervix close to the os for examination. During the scraping the tissue appeared to be sound, and a report by the Clinical Research Association stated that no evidence of malignancy was found in the tissues sent for examination. I saw this patient a few weeks ago, and the still more valuable factor of lapse of time (nearly two years) confirms this verdict, for examination showed that locally and generally she is in good health.

D. A polypoidal hypertrophy of the uterine mucous membrane (especially the glandular and vascular elements), whether of the lining of the body or the cervix, will produce the same kind of discharge. This is only what we should expect, for the walls of these blood vessels are so thin that they bleed on the slightest manipulation, and it is not surprising that oozing should take place either spontaneously or through friction against the vaginal walls.

CASE V. In October, 1896, my friend Dr. Molson sent to me from his out-patient clinique an unmarried woman aged forty-one. Menstruation was scanty, but during part of the intermenstrual period she had an irritating brownish discharge. The uterus was in the forward position, and the cervical canal patulous. A good-sized bright red mucous

polypus protruded from the os. After a course of thuja, which did not alter matters, the polypus was removed by operation. The brownish discharge ceased, and the patient remains well.

CASE VI. In November of last year Dr. Andrew Neatby brought to the out-patient department of the London Homeopathic Hospital an unmarried woman aged thirtyone. For nearly two years she had suffered from excessive menstruation, and for some time had undergone a course of homeopathic medication conducted in a most thorough and painstaking manner, resulting in improvement of her general health, but without diminishing her excessive loss, which in some instances was stated to last three weeks. On closer questioning it was discovered that although true menstruation was both profuse and irregular, a considerable part of an ordinary intermenstrual interval was occupied by a dark scanty discharge varying in color and consistence. After the continuance of this for a few days it gradually lost its characteristics and remained as a stringy, yellowish or whitish discharge. There was no vesical irritation or iliac pain suggesting specific inflammation. After a couple of months of much cruder, but not more effectual, treatment at my hands, it was decided to explore the uterine cavity. It was dilated sufficiently to admit a finger. the fundus was found projecting into the cavity a small polypus of fairly firm consistence. This was scraped away, the uterus was curetted, and the cavity packed with gauze. The two periods since the operation have been four to six days, brighter in character, and less profuse in quantity. One of the periods began with a discharge like dark brown glue. There was much less leucorrhoea than before. This patient is still under observation, and it is too early to say she is cured.

E. Another condition analogous to that just mentioned in which I have occasionally observed colored discharge, is urethral caruncle. This is also sometimes present in conjunction with offensive leucorrhæa, but I have no recorded evidence of a discharge both colored and offensive being

present when no other condition than urethral caruncle is discoverable, though I believe such is sometimes the case.

F. Perhaps the most important cases are those in which colored offensive discharge is associated with the presence of a uterine tumor. Certainly, this connection at once enormously enhances the difficulty of arriving at a just conclusion as to the nature of our patient's malady—bringing us face to face with issues of the gravest import.

CASE VII. The first time I realized that this condition was sometimes associated with uterine fibroids was in 1804. when Dr. Cook asked me to see with him a patient who had an enlarged uterus. She had not passed the menopause, and she had between the periods a profuse, dirtycolored, and extremely offensive discharge. The odor was so pronounced that it was perceptible some distance from the patient's bed, and was extremely difficult to remove from the examining fingers. It suggested rather a gangrenous condition (e. g., of a polypus), but the duration of the condition, the absence of fever or other indications of septic intoxication negatived this supposition. It was diagnosed to be malignant disease, and hysterectomy was performed. The specimen is in the museum of the London Homeopathic Hospital, and shows a well-marked interstitial myo-fibroma. The Clinical Research Association issued a report, which states that the tumor "is permeated by many capillary vessels, but there is no evidence of malignant disease in it. Sections of the wall of the uterine cavity show diffused inflammatory thickening of the mucous membrane (endometritis). There are abundant catarrhal changes in the uterine tubules, and much small cell growth around them, but there is nothing to indicate malignant disease."

I have subsequently seen at least one case where the diagnosis was equally uncertain, and where at a consultation some of my colleagues disagreed with me, and on the strength of the character of the discharge concluded in favor of malignancy. Post-operational examination showed again myoma and endometritis. In at least two cases which I now call to mind, where the diagnosis of myo-

fibroma was undoubted, brownish and offensive intermenstrual discharge co-existed.

G. Finally come cases of vaginitis and "cervical erosion"—glandular hypertrophy of the cervical mucous membrane. Pathologically these cases should have stood between the endometritis and polypus cases already referred to, but clinically they are best classified separately.

CASE VIII. In 1889 Fanny S. first came under my care. She first complained of abdominal pains and "spasms." Later on she developed attacks like catarrhal enteritisacute pains and profuse frequent straining diarrhea. Still later, in 1804, she had several attacks of pelvic peritonitis, the cause of which was diagnosed to be tubal catarrhal inflammation. During the years from 1890 to 1894 she developed dyspareunia and a neurotic condition. Her health was so bad and her pain so constant that toward the end of 1804 I removed the uterine appendages. Since then she has had no painful diarrhea or peritonitis, but dyspareunia persisted and vaginitis with cervical erosion was found. The vaginitis and erosion were accompanied by a blood-stained discharge of an excoriating nature. The discharge ceased after local treatment, but the dyspareunia persists.

SUMMARY. While not pretending to deal exhaustively with this subject, I think I have alluded to most of the conditions in which the symptom at the head of my paper occurs. No books have been consulted in its compilation, so that while it is possible some diseases unmentioned here may have been noted by others where colored offensive leucorrhœa has been present, its proportional clinical significance as it has impressed itself upon me during some years in a fairly large clinique is here recorded.

It is hardly necessary to state that the group is only united by the one clinical symptom, and only presented together here that the diagnostic worth of the symptom may be duly appreciated in the light of the examining couch, bedside, and operating table.

A word, perhaps, is necessary as to the nature of the

discharge referred to. No two cases are probably exactly alike in this respect—even cases of the same disease differing widely. In some instances the secretion is thick, in others thin; now it is of a dark color, and again very pale; sometimes it is chiefly blood, at others it is barely stained. In the same patient it may vary in some of these points, as also in the odor present. The voluntary description of the patient, or that accepted by her, will have a significance varying with the individual's intelligence or imaginativeness. Nevertheless it appears to me that the expression "a colored or blood-stained offensive discharge" will cover the whole, and it is here many cases clinically meet, though therapeutically finer descriptive differentiation is needed. The various maladies, then, in which it is not uncommon to find such a discharge, not necessarily in order either of frequency or importance, are as follows:

- 1. Malignant uterine diseases.
- 2. Retained products of conception.
- 3. Endometritis-senile, parous, and virginal.
- 4. Mucous polypus, intra-uterine and cervical.
- 5. Urethral caruncle.
- 6. Uterine myo-fibroma.
- 7. Vaginitis and cervical erosion.

As inference from the facts adduced I would venture to emphasize my belief:

- a. That such a discharge calls for prompt if not immediate physical examination. In the case of married women the examination should be immediate.
- b. That where a tumor is present, and the other signs and symptoms do not unerringly indicate the nature of the case, the uterus should unhesitatingly be dilated, and its cavity explored with finger or curette as may be necessary.

SOME OF THE RELATIONS OF PREGNANCY TO SURGERY.

By Mayo Robson, M. D.

THE relations of pregnancy to surgery which are of paramount importance are:

- (A) The question of general surgical operation during the course of pregnancy.
- (B) That of pregnancy simulating other abdominal tumors; and
 - (c) The subject of ectopic gestation.
- (A) OPERATIONS PERFORMED DURING THE COURSE OF PREGNANCY.

The important fact I would point out is that, although a number of the operations of this character which I have performed were of a serious nature, in no case except one did premature labor come on, and in that one case it followed so distinctly on an emotional trouble after the wound was healed, that I think it might be fair to say that in no case did the uterus empty itself as a result of operation.

Although the old canons of surgery hold good in so far as they would lead us to avoid operating during the course of pregnancy, yet experience shows that our grounds for observing unwritten law are quite altered; for now we can not only do away with shock by the use of anæsthesia, but by the observance of antiseptic precautions wound complications in the shape of pain, fever, and suppuration are avoided.

The change is well illustrated by what was told me by an able surgeon very much my senior, who, speaking of bygone days, said he had performed ovariotomy four times during pregnancy; all the patients had miscarried, and one had died. Then it was apparently a matter of chance whether or not the patient would miscarry after operation, the chances being in favor of miscarriage. Now, it would

seem to me the question of chance is eliminated in a great measure, and that should an operation be decidedly to the advantage of the patient, it may be undertaken with every probability of success.

(B) PREGNANCY SIMULATING OTHER ABDOMINAL TUMORS.

It would be tedious to relate all the cases I have seen of pregnancy mistaken for ovarian tumor or for myoma of the uterus; for instance, in one week I had three cases sent to me as ovarian tumor, all of which proved to be instances of pregnancy. Sometimes the mistake arises from a too implicit trust in human nature; for instance, it is hard to believe that a spinster lady of position, aged forty-nine, who has missed her periods, and has developed an abdominal swelling, should be suffering from pregnancy, but a case of this kind came to my notice only last year. The patient herself was evidently deluded, but the fetal heart-tick speedily settled the diagnosis, and her medical man asked me to allow him to explain matters to his patient at home, which I was only too glad to do.

In another case of this kind, a leader in a small church, aged forty-seven, was so much above suspicion that disease was taken for granted, and a vaginal examination was thought to be such a dreadful ordeal that I had to make my diagnosis by means of the stethoscope.

In one case an appointment was made by telegram for me to see a lady at my rooms along with her medical man, the case having been diagnosed as a uterine tumor. On examination, I found the os dilating, and had to advise a return home by the next train.

Within one month two cases were admitted under my care at the infirmary as a uterine and an ovarian tumor respectively, and diagnosed as such by their medical attendants, both men of experience and skill. Curiously, both brought forth permaturely the day after admission, the uterine tumor being a case of hydramnios, with twins, the ovarian being an ordinary case of pregnancy. The latter case was simply an oversight on the part of my medical

friend, who accepted the patient's statement that pregnancy was impossible, and relied on an examination through the clothing. The former "hydramnios" was more difficult of diagnosis, and, as the twins were dead and quite small, the only certain sign to be obtained was ballottement; as a matter of fact, the diagnosis of hydramnios was arrived at before the uterus expelled its contents.

I have seen two other cases of hydramnios to create a difficulty in diagnosis; in one an operating surgeon asked my opinion on a case he was going to operate on within the week. The abdomen was an enormous size, but the feeling of solid through fluid made me suspicious, and I suggested the use of the exploring syringe, which drew off liquor amnii and cleared up the diagnosis of the case. In the other, an eminent surgeon whom I knew actually performed hysterectomy, and only after removal it was found that the uterus contained shriveled twins.

From these, and many other cases that I could relate, I always feel it my first duty in making a diagnosis of abdominal tumor to eliminate pregnancy. At times, in the early stages, this may be difficult without the passage of the sound, which would, of course, bring on abortion, and which would be unjustifiable; but such cases will, as a rule, wait if necessary until the period of quickening is reached, when the fetal heart can be heard. The bimanual examination with or without an anæsthetic in the case of pelvic tumors, and the stethoscope and other signs when the tumor has become abdominal, will usually overcome all difficulties; at all events, in a tolerably large experience these precautions have so far kept me from real difficulty, and I have not yet had the mortification of opening a pregnant abdomen unintentionally.

(C) ECTOPIC PREGNANCY.

This subject is one of not less scientific interest than practical importance, for not only does it offer several problems difficult to explain, but from its frequent occurrence, its alarming and dangerous symptoms, and its curability if treated scientifically, its study becomes of the first interest to the general medical practitioner as well as to the operating surgeon.

It is a curious fact that in every female mammal above the monotremata there is a section of the genital canal between each abdominal ostium and the uterus, in which under normal conditions the impregnated ovum is not retained, and that, so far as is at present known, the lodgment and growth of an impregnated ovum has only occurred in this situation in women, when the disease is known as tubal pregnancy or extra-uterine fetation, or ectopic gestation. Perhaps it is that woman only suffers from desquamative salpingitis, which Mr. Lawson Tait says is always present in such cases, though in one of my cases there was apparently no evidence of this. Tubal gestation is of interest also from the many accidents that may occur in its course. The position of the ovum in the tube and the site of the placenta predisposing to the special form which the case will take.

It seems convenient to divide the tube into thirds, as the outer third is completely invested by the peritoneum; the middle third is only partly invested, and has the mesosalpinx below; while the inner third is placed in the uterine wall.

In the outer two-thirds rupture of the tube usually occurs in the third to the tenth week, rarely beyond the twelfth, but in the inner third it may not occur until the fifth month.

It is impossible now to enter into all these varieties of the disease in question, many of which I have seen and operated on, and I propose to limit my remarks simply to the dreadful accident of intraperitoneal hematocele, which practically always depends on the rupture of a pregnant tube.

A case of this kind once seen is never forgotten, and in no class of cases is the value of early surgical treatment brought home so forcibly, both to the patient and her friends as well as to the medical attendants themselves, as in this. I have had the privilege of saving several valuable lives after this accident, and in only one out of a number of cases has death followed on operation, and in that instance the patient had lost blood to an enormous extent and died of pulmonary thrombosis the night subsequent to operation. I will only relate two examples, but they will serve to illustrate my remarks.

About eleven o'clock one morning a medical friend called and asked me if I would see his wife, who had been taken suddenly ill at breakfast, and had been carried to bed in a fainting condition; she was only recently married, and had missed one period a fortnight before.

I found her only partly conscious, and pulseless, looking as pale as the sheet on which she was lying; the history of a sudden pelvic pain, followed by faintness and the presence of a fluid thrill in the lower abdomen at once rendered the diagnosis clear, and within a very short time I had the abdomen opened, and a ruptured tube still bleeding ligatured and removed. Several pints of blood and clot were washed out of the abdomen, and drainage was adopted. Recovery was speedy, and the patient is to-day in good health.

In another case Dr. Drake asked me to see with him a young married lady, who had been suddenly seized while at the railway station with pelvic pain, followed by faintness, and on arrival at home by repeated fainting attacks. The same history of a missed period and the presence of fluid in the abdomen led to a diagnosis which an abdominal section verified. After removal of the ruptured tube, and after clearing the abdomen of blood, speedy recovery ensued, and that lady is now in good health.

The important point to bear in mind in these cases is that delay is worse than useless, it is positively dangerous; and though in a case I saw at Ripon we succeeded in saving life by operating on the second day, there may be no second day reached, and if we want to be certain of saving life we must interfere at the earliest possible moment.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

TRUE TO THEMSELVES. A Psychological Study. By ALEXANDER J. C. SKENE, M. D., LL. D. F. Tennyson Neely: New York.

The object of Dr. Skene's book, for it points a moral as well as adorns a tale, is to show that the conduct of the characters he portrays could not be otherwise than what it is. They are true to themselves. That while they appear to act in contravention of the accepted rules of conduct upon certain occasions it is in obedience to psychological promptings. From the earliest times students of psychology have noted exceptional phenomena that seemed to indicate the action of the soul independent of the body to which it belonged. It is the consideration of these phenomena that engages the attention of Dr. Skene and his psychological study consists in the submission of examples—examples taken from widely different social relations, that show their utter inexplicability from any other point of view than the soul's independence of the body, on occasion, during the lifetime of the individual.

A TEXT-BOOK OF THE DISEASES OF WOMEN. By HENRY J. GARRIGUES, A. M., M. D. Professor of Gynecology and Obstetrics in the New York School of Clinical Medicine, etc., etc. Second Edition. Thoroughly Revised. Philadelphia: W. B. Saunders, 1897.

Condensed, clear, and comprehensive was the verdict passed upon this work at its appearance, a verdict which has been sustained by the exhaustion of the first edition within a few years of its appearance, a substantial and flattering mark of approval. The first edition was issued so recently and the work was so complete that comparatively few changes have been required to bring it down to date. In this edition old fashioned patterns of instruments have been replaced by new ones, and new illustrations have been added. The subjects of Aseptic Surgery, the Surgical Treatment of Uterine Fibroid and Cancer, have been rewritten

and descriptions of the chief methods employed in intestinal surgery have been added, making it one of the most useful and practical works for the general practitioner upon this subject we know of.

NERVOUS DISEASES, WITH HOMEOPATHIC TREATMENT. By JOSEPH T. O'CONNOR, M. D., Ph. D., Professor of Nervous Diseases in the New York Homeopathic Medical College and Hospital, etc. etc. Illustrated. New York: Boericke, Runyon & Ernesty. 1898.

This thoroughly homeopathic treatise upon nervous diseases is at once an amplification and a condensation of Professor O'Connor's lectures delivered at the medical colleges with which he is connected. An amplification of the descriptive parts of the lectures and a condensation of the anatomical details. the preparation of the material the author has drawn not only upon his own wide experience but also upon the experience of the investigators and clinicians everywhere and has produced a concise and practical book, valuable alike to student and practitioner. The description of the different morbid conditions, their ætiology and pathology, is full and complete and presents the latest accepted opinions, while the treatment is essentially homeopathic, the author regarding homeopathy within its limitations as invincible. The introductory chapter and those upon Examination and Electric Diagnosis will repay careful reading. The book is finely printed, well bound, and a valuable addition to the literature of nervous disease

MEDICAL AND SURGICAL DISEASES OF THE KIDNEYS AND URETERS. By BUKK G. CARLETON, M. D., Genito-urinary Surgeon and Specialist to the Metropolitan Hospital, Blackwell's Island. Illustrated. New York: Boericke, Runyon & Ernesty. 1898.

This volume, a companion to the author's manual on Genito-Urinary and Venereal Diseases, is a practical working book for the general practitioner. In it the author has incorporated all the new facts from reliable sources together with the result of his personal experience. As a practical work theories have been omitted. The ætiology and pathology of each disease are fully considered as well as the medical and surgical treatment, the homeopathic treatment being clearly and fully set forth. In addition to the indications given under each head, a chapter

has been devoted to the symptomatology of the remedies applicable to these conditions. To those who are familiar with the author's previous work this book will require no commendation, to those who are not, we would say that they will find them both valuable additions to the working library.

THE PRESCRIBER: A DICTIONARY OF THE NEW THERAPEUTICS. By JOHN H. CLARKE, M. D., F. R. G. S. American Edition. Revised and Enlarged by the Author from the Fourth English Edition. Philadelphia: Boericke & Tafel, 1898.

Although this work was designed primarily for the beginner in homeopathic practice as a handy book of reference, the skilled practitioner will find it a convenient book for ready reference when prescribing. The plan of the work is simple, the diseases or conditions being arranged in alphabetical order, with the most prominent remedies for that condition with the symptoms indicating each remedy. It is a book for ready reference and not for study, and as such will serve a useful purpose.

Malgria Agdien.

Camphor in Threatened Abortion.—Dr. Danforth.—Abortion particularly during epidemic influenza.

Moschus in Dysmenorrhea.—Dr. Dahlke.—Drawing pains at the beginning of menstruation, which cease as soon as the flow sets in.

Lilium Tigrinum in Leucorrhoea.—Dr. Allen.—Thin and acrid leucorrhoea causing brown discoloration, worse in the afternoon until midnight, amelioration morning, seems to cause a rash, with swelling.

Sabina in Menorrhagia.—This remedy is indicated by a more active condition than that calling for crocus or china. There are some evidences of congestion or threatening inflammation in the pelvis. The uterus and its appendages are sore, sensitive to touch, the blood is red, arterial.

The Homeopathic Journal of Surgery.—A new journal devoted entirely to surgery and surgical matters will appear about the first of January, 1898. Dr. C. E. Fisher, the able editor of

the Medical Century, will be in charge, and the Medical Century Company will be the publishers.

We believe there is room for such a journal, and under the charge of Dr. Fisher it will be undoubtedly a complete success.

Aslanthus Glandulosa in Scarlet Fever.—Dr. Olds.—There is putridity throughout. The discharges are putrid, offensive; there are putrid ulcers, offensive breath. The eruption comes out in patches, miliary, dark, purple. The skin between the patches of eruption is of a brownish or livid hue, or mahogany color. On the surface, in different parts, petechiæ are thrown out, large blebs form, containing a claret-colored serum, bloody serum; also some blisters in different places. The imprint of the finger remains long on the skin.

Mephitis in Pertussis .- Dr. Dewey, Med. Cent.-Mephitis is useful in a cough with a well-marked laryngeal spasm-a whoop. Cough is worse at night on lying down, there is a suffocative feeling, and the child cannot exhale. Farrington observes that this remedy will often apparently make the patient worse, while it really tends to shorten the course of the disease. The catarrhal symptoms in cases calling for mephitis are slight, but the whoop is prominent. The smothering comes on with the cough, while with corallium rubrum it comes on before the cough and is followed by great exhaustion. There is not much expectoration with mephitis. Fisher, in his "Diseases of Children," prefers naphthalin to mephitis in whooping cough. The writer has also seen good results from naphthalin. One of Hahnemann's therapeutic hints in whooping cough is ledum, which has a spasmodic racking cough and should be thought of in connection with this affection.

Aletris Farinosa in Gynecology.—Dr. Dewey, Med. Cent.— One symptom should mark this remedy as an especially useful one in female disorders, and that is "tired all the time."

The menses are premature and profuse, with labor-like pains.

In uterine displacements and leucorrhœa it is an excellent remedy, being indicated by the accompanying extreme constipation, in which great efforts are required to evacuate the bowels; digestion is weak.

Is is one of the bitter tonics resembling somewhat helonias and senecio, which was Dr. Holcombe's remedy for retarded or suppressed menstruation where the patient is nervous, hysterical, and sleepless. The characteristics of aletris, therefore, are the tired feeling, the extreme constipation, and the weakness of digestion accompanying uterine displacements or leucorrhoea.

Calcarea Ostr. in Threatened Abortion.—Dr. Danforth.— Threatened miscarriage in those who generally have profuse menses, or are subject to hemorrhages.

Terebinthina in Albuminuria of Pregnancy.—Scanty, dark-colored urine, with blood and albumin present. This remedy is especially useful in acute congestion of the kidneys, rather than where there is an inflammation of them.

Tellurium in Ringworms.—Face and body thickly covered with ringworms, especially on lower limbs (sepia on face and upper parts of body); rings intersect each other, in some places very thickly, so as to almost obliterate character of disease (sepia rarely if ever intersects); great heat of skin; restlessness; thirst; rapid pulse; headache.

Sepia in Backache.—Hahn.—Has the labor-like pains which are felt chiefly in the back, accompanied by a feeling as though she must cross the limbs and "sit close" to keep something from coming out through the vagina; pains in other parts of the body go to the back; sudden pain in back, as if struck with a hammer; pains are better by pressing the back against something hard; the backache causes nausea and a faint feeling when standing; the spine is tender to the touch.

Lilium Tig. in Ovarian Disease.—Dr. McMichael, Hahn.—Stinging, sharp, darting, cutting and bearing-down pains in left ovary, slightly relieved by moderate pressure and gently rubbing, worse evening and night. Bearing down in uterine region, worse walking, better holding up the abdomen with hands. Acrid leucorrhœa, leaving brown stain; displacements with pressure against rectum. Palpitation of heart. Constant desire to urinate.

Phytolacca in Scarlatina.—Dr. McElwee, Med. Cent.—Scarlet eruption all over the body; high fever; headache; both sides of the throat covered with ash-colored membrane. Eruption dry, of a shriveled appearance. In passing hand over the skin, it feels like brown paper. Urine suppressed; hands and feet burning hot; cannot keep them covered; restless and sleepless; tongue dry in center and sides coated brown. Acrid coryza, eruption doesn't appear properly (bryonia, lachesis).

Hyoscyamus in Rachitis.—Dr. Payne, Clin.—Is an excellent remedy for the extreme nervous excitability with tendency toward epileptiform convulsions, with incontinence of urine. The child suddenly sickens after eating, vomits, and shows distress in stomach. It suddenly shrieks and then becomes insensible.

Gelsemium in Measles .- Dr. Dewey, Med. Cent. -- Gelsemium is, on the whole, a more useful remedy in commencing measles than aconite; that is, it is oftener indicated. There is much chilliness, the fever is a prominent symptom, the child is dumpish, apathetic, does not want to be disturbed; there is a watery coryza which excoriates the upper lip and nose, and there is a barking, harsh, croupy cough, with chest soreness and Gelsemium, too, has an action on the skin, and may be continued with benefit after the eruption has appeared; there is an itching and redness of the skin, and a decidedly measly eruption produced by it. It has some aching of the limbs, and may be compared with dulcamara, but hardly ever need be mistaken for that remedy. Gelsemium has more coryza, dulcamara more aching. Both may be used in undeveloped eruption; gelsemium when there is pain at the base of the brain, high fever, and passive brain symptoms; dulcamara when occurring from damp, cold air, rainy weather, or sudden changes.

Gelsemium in Puerperal Convulsions.—Mrs. G., aged twenty-four years; expecting her fourth child, complained of a raging headache, the fingers were convulsively closed, the feet icy cold, the head hot, the face bloated. I had warming-pans applied to the feet and sent home for tincture of gelsemium.

Five minutes after my arrival she had the first convulsion, and this was followed by five more; these were more violent than any I had ever seen before. There were no labor pains, but the water had passed off the day before, as the nurse reported. The os uteri was only slightly dilated. I at once mixed twenty drops of tincture of gelsemium with half a tumbler full of water, and gave a teaspoonful every five minutes, but had much trouble in getting her to swallow. In half an hour the muscles began to relax somewhat and the convulsions diminished, and after an hour the patient regained her consciousness, the pulse was softer, and all the symptoms milder.

Next morning I found the patient cheerful and bright; the headache, from which she had suffered almost continually for

almost fourteen days, had almost disappeared. The patient was directed to keep her bed and received gelsemium 3x every three hours for two weeks. Then I was again called and found the patient in full labor, but the parts were very dry and hot. I had the parts well anointed with oil and in ten minutes there followed the delivery of a healthy girl.

Obstehries.

Is the Vagina in Normal Pregnancy Aseptic?—Dr. Goenner, after careful investigation of the normal secretion of the vagina in healthy pregnant woman, finds that it contains anærobic bacteria, not such as cause primary septic endometritis, but those which can be easily introduced from without. As in the case of streptococci which set up puerperal fever, the germs in the vagina do not represent auto-infection, but are brought there by the medical attendant, the midwife, the nurse, or the instruments. Septic endometritis, often indicated by fetid liquor amnii, may be excited by the bacterium coli.

Delayed Expulsion of Second Twin.—Drs. Lelarge and Verchère, Revue de Gynéc. et de Chirurg. Abdom., record the case of a multipara who aborted of a six weeks' fetus on June 12, She rose ten days later; there was much sero-sanguineous The uterus was bulky, the os uteri patulous, and subinvolution was diagnosed. The uterine cavity was swabbed with glycerin of cresote, and this treatment was repeated eight times. The sound passed three inches. The discharges disappeared, and the patient made excursions in a mountain watering place. On September 2, the day after her return to Paris, labor pains set in and the leg of a fetus was seen projecting from the The fetus was extracted, and it appeared to have attained the fourth month. The placenta could not be removed till four hours later. Thus the pregnant uterus tolerated the sound; eight applications of the cautery; the fatigues of a long voyage, and the exertions of long walks up and down mountain paths. The authors remark that the diagnosis of early pregnancy is by no means easy, and that the sound should never be passed without certain precautions being taken. The fact that abortion

does not invariably follow the passage of that instrument within a few days is no disproof of pregnancy.

The Fertility of Twins.—Brit. Med. Jour.—There is a widespread idea that of twin sisters both never become mothers. The germ of truth in this statement was known even to Pliny who says, "if a woman bring twins, it is a great goodhap if they all live, but either the mother dieth in childhood, or one of the babes, if not both. But if it fortune that the twins be of both sexes, one male the other female, it is ten to one if both of them escape." Indeed "a left twin" is one of the commonest objects among the poorer classes to this day, where it is spoken of with bated breath. Arrived at maturity twin sisters are supposed to be sterile, but upon quite insufficient grounds. There are undoubted cases where both girls have married and have had large families. The error seems to have arisen from too limited an observation upon the part of farmers who have applied what is partially true of cattle to what is quite untrue of their own offspring. In cattle, twin ewes always breed, unless one is an hermaphrodite, while in the case of calves, when one is a bull and the other a female, the latter hardly ever breeds but grows up like an ox. Such a cow calf is well known to breeders as a "freemartin," and it presents evidence of marked imperfection or malformation of the genital organs. There is no doubt in the mind of anyone that twin brothers, like twin bulls, are perfectly virile, and there is no reason to suppose that twin sisters, otherwise healthy and well-formed, are not equally apt to conceive.

Ectopic Pregnancy of Old Date.—Dr. Fort, L'Abeille Méd.—A woman who ten years previously had thought herself pregnant, and had applied for the help of a midwife at her expected term, had latterly suffered a great deal from the troubles caused by a hard tumor which had existed ever since her supposed pregnancy. His diagnosis was fibroma of the ovary, instead of which he found a fetus. Denis, in a laparotomy done on account of vesical and intestinal troubles, found a fetus that had been twelve years in the abdominal cavity without showing signs of maceration or forming a lithopedion. The death of the fetus had not caused any particular symptoms, not even labor pains.

Influence of Pregnancy on Diseases of the Heart.—Dr. Jaccoud, Sem. Méd.—Pregnancy is always liable to cause serious disturbances of the cardio-pulmonary circulation, and to throw

additional work on the heart. Patients who suffer from mitral lesions, which rapidly affect the lesser circulation, frequently manifest toward the fifth or sixth month "gravido-cardiac" symptoms—namely, dyspnæa and hemoptysis. Still it is obvious that a diseased heart up to a certain point may suffer no inconvenience from pregnancy. A too hard and fast line should not be drawn in advising or withholding consent to marriage. wishes and ideas of the patient should be considered, and also the depressing and injurious effect upon the heart of withholding consent. The degree of the lesion and the absence or presence of gravido-cardiac symptoms should be noted, the latter forming a decided bar to marriage, though the effect of treatment upon this condition should determine the final decision. The occupation and surroundings of the patient, the possibility of her taking prolonged rest if necessary, should be considered. A milk diet is of great importance: two or three liters should be taken daily from the second or third month of pregnancy. This is a powerful aid to the circulation by reason of its diuretic action, and not only are the gravido-cardiac symptoms warded off, but the appearance of albumin in the urine is prevented.

Premonitory Symptoms of Puerperal Fever.—Dr. Ferre. British Med. Jour., lays stress on the success of intra-uterine treatment for puerperal fever. This success stands in direct ratio to the earliness of intervention. Hence very careful clinical researches have been made in lying-in hospitals in order to detect true prodromata. The true vigor, local pains, and conspicuous. pulse and temperature are known to all, and when combined indicate more or less advanced infection. These symptoms never come on suddenly, though certain milder types of infection now observed may represent sepsis modified by antiseptic These milder types, however, will assuredly develop into deadly septic infection if neglected. Even the severest form is preceded for a day or two by distinct elevation of temperature and pulse, and by insomnia. An evening temperature of about 100° in the axilla, with a fall of about a degree in the morning, without a corresponding drop in a somewhat rapid pulse, is a distinctly suspicious symptom. The rise in the pulse often precedes the rise in the temperature: the observer must therefore make sure that acceleration of the heart's action is accounted for even in a patient who seems otherwise convalescent. Reaction after the fatigue of labor, hemorrhage, and emotions all send up the pulse. Insomnia is often observed in the earlier stages of infection, distinct want of sleep without restlessness is usual for a day or two before bad septic symptoms. The lochia may remain free from odor in the premonitory stage of puerperal septicæmia, nor are the discharges always fetid when the disease is established.

Diagnosis of Ectopic Pregnancy.—Dr. D. von Ott, Wiener medizinische Presse, states that swelling of the uterine tissue in the vicinity of the internal os uteri, so important for the diagnosis of normal pregnancy, is lacking in ectopic pregnancy, and the organ retains its pear-like shape. Menstruation usually is only absent for one and a half to two months, when hemorrhages either of an intermittent or irregular character appear; they may also be constant. These, however, have no connection with menstruation, but are due to the hyperæmia and the formation of decidua in the uterine cavity. The ovaries are as a rule enlarged, hyperæmic, and not infrequently present a corpus luteum cyst of unusual size. Sometimes ripe follicles degenerate into large cysts. The unaffected tube is also hyperæmic, and not infrequently by inflammatory changes becomes atresic, and is transformed into hydrosalpinx. In cases where a diagnosis is difficult he advises curretting the uterine cavity, in the hope of getting shreds of decidua for the purpose of a diagnosis. In case that the fetus had died a crackling sensation in the tumor is characteristic.

The Diagnosis of Early Pregnancy.—Dr. Gardner.—The value of the sign of "morning sickness" is very much overestimated. A typical morning sickness is not infrequently met with in patients who have a uterine displacement or an extensive salpingitis. The breast signs are most constant and most reliable in those pregnant for the first time. The enlargement of the papillæ comes the earliest, and is the most constant and easily recognized. Enlargement and tenderness on pressure are very early and constant signs. The fat breast is large, soft, and, even in primipara, is more or less pendulous, while the breast of early pregnancy is firm and stands out from the chest wall.

By the end of the third month milk is present in nearly all cases. Pigmentation of the areola never entirely disappears and thus this sign is of very little value after the first pregnancy.

The blue discoloration of the vagina is of great value in the later stages of gestation. In seventy-five cases under three months it could be detected fifteen times.

The velvety feel due to the superficial softening of the vaginal portion of the cervix was found in all of the seventy-five cases. A similar condition is, however, found in some of the inflammatory conditions of the uterus. In a very large percentage the uterus was found tilted forward. The most important of all signs in the early months, and one without which he does not make a diagnosis, is the cystic feel of the uterus. Practically a cystic uterus is always a pregnant uterus. There is, however, one exception to this statement—a cystic fibroid will give nearly the same sensation as a pregnant uterus. The variety of the cystic fibroid, its comparatively slow growth, and the absence of other signs of pregnancy make the diagnosis clear.

Placenta Prævia.—Professor Hofmeier, Würzburg.—I shall describe as placenta prævia that particular condition in which the os being still closed, there exists over it a portion of placental tissue, whatever the extent of this overlying placenta. According to the dimensions of this portion of placenta, there is placenta prævia partialis, or placenta prævia totalis or centralis.

As regards its anatomical formation, judging from a study of cases published and from my own personal observations and experiments, I have come to the following conclusions:

- (1) A placenta prævia will be formed when, after the ovule has become enveloped in the caduca reflexa and after its ulterior development, the caduca splits up, the process of division extending as far as the internal orifice or its immediate neighborhood; or again, in cases of placenta marginata when, by the same process of division of the caduca, the internal orifice is enveloped by the placental villi;
- (2) Placenta prævia may also arise from a reflexed placenta being placed over the internal orifice.
- (3) It is very doubtful whether placenta prævia may ever arise from direct implantation of the ovule over the internal orifice, the anatomical and embryological conditions of the parts, such as we now know them, militating strongly against this hypothesis.

It has been asserted that miscarriage was of frequent occurrence during the first months of pregnancy, owing to the presence of a placenta prævia; my own experience does not allow me



either to deny or to confirm this assertion. Generally speaking, however, it may be granted that such a placental formation may more easily lead to interruption of the pregnancy than would be the case under normal conditions.

It is a well-known fact, that, in cases of placenta prævia, the pregnancy is often interrupted during its second half, the commonest cause of this interruption being constituted by the hemorrhage which comes on at this time. It arises more particularly from small slips or displacements occurring between the uterine . wall and the placenta, or from small tears in the caduca which closes in the intervillous space near the cervix uteri. These lacerations are caused either by external agencies or by uterine contractions, occurring during the last weeks of gestation, which may extend as far as some venous sinus of the caduca or even open into the intervillous space, whence arises a more or less copious hemorrhage, in nearly every case of venous origin. The intensity and the importance of this hemorrhage are not at all proportional to the size of the portion of placenta overhanging the cervix; it may become rapidly fatal with a placenta of small dimensions, and it may, on the other hand, be neither dangerous nor abundant with a very bulky placenta prævia. I have been able myself to ascertain that the hemorrhage is earlier in cases of partial placenta prævia, only occurring toward the end of the pregnancy with central placenta prævia. The only explanation I can suggest of these facts is that, in the first case, detachment or sliding of the small free portion of the placenta takes place more easily than in the second case, in which the placenta is inserted all round the internal orifice.

The diagnosis is based in the first place on the existence of hemorrhage and of placental tissue over the cervix. Persistence of the hemorrhage after rupture of the amniotic sac is in favor of premature detachment of a normally located placenta, or at any rate of one situated in the upper part of the uterine cavity.

The distinction which I have established for the study of the anatomical disposition of the parts, between placenta prævia, properly so called, and placenta inserted very low down, is no longer useful or possible when we pass on to discuss the treatment, for in either case the essential symptom, hemorrhage, is the same.

The primary indication of treatment in all cases of placenta

prævia is complete arrest of the hemorrhage. This indication is of such paramount importance that the question of the existence of the fetus passes entirely into the second rank, the greater number of such children not being viable or being destined to contend with such heavy risks during labor that their life must be put in great danger.

When the first hemorrhage comes on during pregnancy, the cervix being still closed, we must have recourse to forcible, tight plugging of the vagina with sterilized or iodoform gauze. This should be renewed and kept in as long as the hemorrhage lasts. All authors are unanimous as to this primary indication; but opinions differ as to whether the plug ought to be left in until the cervix is completely dilated in cases in which the hemorrhage only comes on at the very beginning of labor, the orifice of the cervix only admitting one or two fingers. Infection, it is true, is much less to be dreaded nowadays, provided one has been careful to disinfect the vulva and vagina thoroughly before applying the plug, and provided one has already at hand all necessary materials, aseptic or sterilized.

Even then shall we always have recourse to plugging? In my opinion, the course to be adopted depends in each case on the circumstances in which the patient is placed: if she is not living too far from her medical attendant, or if it is necessary to gain time and to brace up the general condition of a patient, already weakened by repeated hemorrhage, the tampon may be applied without any risk; but it should never be kept in for several days in succession, unless there are some imperative indications for so doing. As soon as labor is begun, the best way of arresting the hemorrhage is to rupture the amniotic sac; this will prevent further detachment of the placenta. The presenting fetal part, when coming down and pressing on the inferior segment of the uterus, exerts very effective compression on the bleeding surfaces.

Experience teaches us that, in a large number of cases, more particularly in head presentations with partial placenta prævia, the hemorrhage is in this way completely arrested and labor goes on spontaneously and normally to its termination. But this procedure does not meet the requirements when the placenta has become detached on a more extensive scale, when the uterine contractions are inefficient and irregular, and when the hemorrhage continues notwithstanding the loss of the waters.

It is safer therefore not to content one's self with rupture of the pouch, but to follow it up at once with combined version and forced extraction of one foot. I am bound to say that by the adoption of this method, first recommended by Braxton Hicks in every case of placenta prævia, I have had a larger proportion of successes than with any other means, and this method of intervention has been universally adopted in all German cliniques. The rapid arrest of the hemorrhage after this maneuver is due in the main to rupture of the pouch, but there are also other practical advantages: the uterine contractions become more regular and more active, and, if the hemorrhage does not cease, or if it recurs, it is more easily controlled by traction exerted on the protruding lower limb.

If the cervix and soft parts are but slightly dilated, it will occasionally be advantageous, before proceeding to version and extraction, to introduce into the uterine cavity a colpeurynter, which is gradually filled with water, acting at once as a tampon and as a dilator.

Rupture of the membranes, followed by podalic version, constitutes also the best method of intervention in cases in which it is impossible to reach the edge of the placenta, because of its central implantation and the small amount of dilatation of the uterine orifice. Of course the pouch can only be reached through the middle of the placental tissue, after tearing the chorion and amnios. In most cases, this mode of intervention entails death of the child, but we must admit that under the circumstances there is hardly any possibility of saving it.

When dealing with patients already exhausted by long and copious hemorrhage, it will be necessary after plugging, or after performing version, to see to it, without loss of time, that their circulation is restored, as also their general strength; this is best effected by subcutaneous injections of salt water, of ether, or of camphorated oil, by stimulating enemata, etc.

The period of delivery will also have to be very carefully watched, the uterus often contracting very badly in these cases, more particularly its lower segment on which the placenta had been inserted; then again very firm adhesions often exist between the uterine wall and the placenta, usually the consequence of some coexisting endometritis. An adventitious placenta also is not infrequently present.

As a rule, it is well to remain expectant as long as possible, but various complications which are apt to occur during this period often make it necessary again to interfere by means of intrauterine manual intervention.

Phthisis and Child-Bearing.—Dr. Townsend, Boston Med. and Surg. Jour.—1. Conception may take place even in advanced pulmonary tuberculosis.

- 2. The disease is generally held in abeyance during pregnancy, although it may advance or even originate at this time.
- 3. Labor is short and easy in proportion to the severity of the disease.
- 4. During the puerperium a rapid advance, leading in some cases to speedy death, occurs; or the disease may originate at this time. In either case the temperature chart suggests puerperal sepsis.
- 5. Premature labor is more common the more advanced the disease, although pregnancy often goes on to full term even in advanced cases.
- 6. The average weight of the full-term children and their general condition at birth is not markedly below that of children of healthy mothers, except in the rare instances of congenital tuberculosis.

Toxemia of Pregnancy.—Dr. Wright.—The chief symptoms of this condition are salivation; disorders of digestion, with sometimes a peculiar taste and constipation; general malaise; anæmia; nervous disturbances or headache; disorders of vision; irritability; deficient excretion of urine or some of its constituents, and albuminuria. Any sign of the slightest departure from ordinary health during pregnancy should make us suspect the advent of general toxemia and should receive careful investigation and thorough treatment. If, for instance, there be general malaise, with slight headache, but no albumin in the urine, let us not be deceived, since albuminuria is one of the symptoms of systemic poisoning and sometimes the last to disappear. Its absence proves absolutely nothing.

A purely milk diet is good for young babes and calves, but not for adult human beings. Yeo, in his admirable book on "Food in Health and Disease," shows clearly that milk is not a suitable food for healthy adults, because it contains an excess of albuminates and fats and that it should be mixed with other foods, especially

the carbohydrates. If it be conceded that milk alone is not the best food for healthy adults, it is difficult to conceive how it can be the most suitable in any case of disease.

In the Burnside Hospital, in nine years they have had sixty-five cases of toxemia with albuminuria with two deaths, both from eclampsia. One of these two patients came into the hospital in a dying condition with eclampsia, having received no previous treatment. In the sixty-five cases there were many cases where the albuminuria and other symptoms were only slight.

The main points of treatment are:

- 1. A carefully selected mixed diet with plenty of water, plain and mineral, lemonade without sugar and the like.
 - 2. Rest, good hygienic surroundings and proper clothing.
- 3. The regular and persistent use of purgatives for weeks or months, with a preference for epsom salts.
 - 4. A warm daily bath.
 - 5. The induction of abortion or premature labor in rare cases.

Cynecological Pląhings.

Wandering of Ligatures into the Bladder after Gynecological Operations.—Dr. Kolischer of Schauta's Clinic, Wien klin. Rundschau.—The use of the cystoscope has shown that it is not uncommon for stitches and ligatures to find their way into the female bladder after operations on adjoining parts, particularly the ovaries and adnexa. This may also occur in vaginal fixation of the uterus; ulceration may go on without unpleasant symptoms arising until the bladder wall is eroded. Then there may be a rigor, with more or less lasting fever, followed by pain in the region of the bladder and frequent passing of cloudy urine containing pus and even blood. In slighter cases pain is absent, and there may only be slight discomfort at the end of micturition; the turpidity of the urine is variable. The author records two cases. In the first, violent bladder symptoms came on suddenly after an ovariotomy, and the cystoscope showed an œdematous swelling 1 c.cm. above the left ureter. It was soft and tender. and on carefully opening it with scissors blood and pus escaped.

After washing out the bladder a ligature could be seen presenting in the minute wound; this was easily removed with cystoscope forceps. The second patient developed the symptoms of acute cystitis six weeks after removal of the adnexa by the abdomen. There was an œdematous prominence in the trigone. A fortnight later this had been replaced by a hole in which lay a ligature. As the process of passage of the ligature through the wall is very slow the author recommends that it be not pulled on by forceps till quite loose; the threads do not incrust very often, but the bladder should be washed out with antiseptic solutions before they are removed. If a ligature appear in the bladder after an operation it must be taken as probable that the remaining ligatures of the same stump will follow, usually through the same channel. They are best got rid of by cystoscope scissors and forceps, and the cystitis they set up is then readily got under. In only one case did a small vesical ulcer persist for some little time.

The Thyroid Gland and the Sexual Organs.—Dr. Fisher states that the relations between the thyroid gland and the female sexual organs have often been discussed, since attention was directed to the fact that goiter predominated in woman, and that from eighty to ninety per cent. of the cases occurred in females. Myxædema, moreover, is met with in women in eighty-six per cent. of the cases. The same thing is found in Graves' disease. and in respect of sclerodermatic processes the proportion as between women and men is three to one. Swelling of the thyroid gland has been observed in puberty, and at the commencement of the menstrual period. Freund found an increase of this gland during pregnancy in forty-five out of fifty cases, and Woelfler has described a case in which during pregnancy the trachea became soft and the goiter increased: Goiters increase during delivery and decrease again some days afterward. Graves' disease also, if it develop during pregnancy, improves after delivery. It is doubtful whether the thyroid gland becomes larger during lactation. but in the climacteric period it undergoes atrophy. Goiter and phthisis seem to be incompatible. In the lower animals extirpation of the thyroid gland causes atrophy of the sexual organs, which is due, according to Hofmeister, to shriveling of the ovarian follicles. Hens with hypertrophied thyroid glands also lay larger eggs than those which have atrophied thyroids. Post-mortem examination of a girl, aged eight years, who was affected with myxœdema, showed that both ovaries were of the size usual at two years of age, and that they contained only a few follicles. The symptoms of Graves' disease depend in some degree on the condition of the patient's sexual development.

A Constant Symptom of Hysteria.—Dr. Strozevski.—A characteristic symptom of this affection, one which, up to the present time, has not been noticed, consists of a complete abolition, or, at least, a very considerable diminution, of excitation upon certain portions of the body, by the contact of a delicate stimulant, such as, for instance, a piece of paper, or a hair.

If, on a healthy person, these spots are touched in this way, a sort of irritation or tickling is produced, with a more or less agreeable sensation. The experiment causes the person to place his hand upon the spot subject to the excitation. The most readily excited points are: The external auditory canal and mucous membrane of the nasal fossa; then the lower eyelid and the skin of the forehead. The least excitable spots are: The armpits, the skin on and under the knees, and the sole of the foot. In these last-named places irritation could be excited with gentle movements of the fingers.

In hysterical subjects the above experiment does not cause any sensation, or, in some rare cases, a very slight sensation. In the study of more than fifty cases of hysteria this symptom has never been found absent, the same being the case in patients who, relieved of their sufferings, were about to leave the hospital. This symptom is equally present in hysteria with depression or with erethism, and in both sexes. It is doubtless of central origin.

Vaginal Douching.—Dr. Giles, Lancet, warns against the almost universal practice of vaginal douching by the laity under the direction of physicians and nurses. The researches of Winter, Doderlein, and others have shown that the vagina is normally inhabited by a certain bacillus to which, through the formation of lactic acid, the acidity of the vaginal secretions is due, and the special role of which appears to be to antagonize and disarm any pathogenic organisms that may enter the canal. But too frequent douching destroys this power of the vagina, and tends to produce a morbid condition rather than a beneficent one. The same rule applies to the practice of giving

a vaginal douche before or during labor; for when this is normal, the uterine and vaginal secretions, followed by the rush of liquor amnii, tend to sweep the passage in the most effective way, namely, from within outward. The prolonged use of the hot douche in many cases produces chronic pelvic congestion.

Pędialrigs.

Dropsy Following Varicella Without Renal Complications.-Dr. Von Starck reports a case, La Semaine Méd., of a girl of two years, who, on the eighth day of convalescence from varicella, suddenly developed an intense and general anasarca. There was neither headache, nausea, fever, nor albumin in the urine, which latter was normal in quantity. The abdominal and thoracic organs were normal. After ten days the dropsy disappeared completely, since when she has been in excellent health. The disease could not have been a nephritis, as there was neither' albuminuria nor transitory renal incompetency, for the urine was entirely normal in quantity and quality, and there were neither headache nor nausea. He ascribes the disease to an affection of the cutaneous blood vessels, due to the virus of varicella. cites a case reported by Quincke (Kiel), where dropsy followed another eruptive fever, scarlatina, but where the kidneys were normal.

A New Treatment of Pott's Curvature.—Dr. Calot, Sem. Méd., affirms that, from his experience of thirty-seven cases, all children with Pott's curvature of the spine can be cured without deformity, by forcibly correcting the curve as soon as it appears. The patient is put under an anæsthetic, while four assistants pull the upper and lower extremity of the spinal column backward, and the surgeon exerts strong pressure on the convexity of the curve. When the spine has thus been straightened, a plaster jacket reaching from the head to the pelvis is applied. If it is impossible to correct the curve by these means, the projecting spinal processes should be removed. Exceptionally, however (in two out of thirty-seven cases), the posterior wedge of bone which prevents the vertebral column from being straightened must be

excised. Then, after cutting through the bone anterior to the spinal canal, the column can be replaced in its normal position. Only five or ten months are needed for a cure, instead of two or three years as under the usual treatment, and the occurrence of paralysis is largely prevented. Calot showed five children before the Academy of Medicine whose humps, after existing for six months to six years, had been treated by his method. In some no trace, in others but very little of the former deformity remained.

Hyperpyrexia in Measles.—Dr. Allison, Brit. Med. Jour.—On December 10, 1896, I was asked to see a well-nourished girl, aged fifteen months, with a history of whooping-cough during the previous five weeks. She was suffering from broncho-pneumonia, the respirations being 70 and the temperature 104°. The face was somewhat livid, and the eyelids glued together with secretion. I ordered medicine and a hot bath, and in the evening the temperature was 102° and the respiration 60.

Next day a rash was visible on the forehead at the roots of the hair; the temperature was 104.2°, and the respirations very shallow and rapid.

At night the nurse sent me word that the temperature was 109°. On arrival I learned that the child had had two slight convulsions, and had been given a hot bath. On putting my thermometer into the axilla, I found it to register 107°, while the nurse showed me her thermometer still registering 109°. This had been taken before the bath.

The patient was cyanotic, restless, and apparently unconscious. The rash had disappeared. The breathing was extremely quick for five or six respirations, and then came a long pause, followed by a struggle to get rid of the bronchial secretion, which threatened to choke her. During respiration hurried, harsh breath sounds were present over the left chest behind, while abundant moist râles were heard in addition over the right. Both sides were resonant, with the exception of a slight area of dullness at the base of the right lung.

I gave antifebrin grs. ijss by the mouth, but as anything swallowed tended to set up an attempt at whooping-cough (seemingly overshadowed by the pulmonary condition), I administered atropine hypodermically, which checked secretion and calmed and regulated the breathing. On now rubbing the body back and

front with ice the temperature was brought down, but it quickly went up again to 109° by the nurse's thermometer and to 109.2° by mine; both records being taken in the axilla. Ice was again applied to the body, and as the temperature fell the forehead was seen first to become flushed, and then the characteristic rash of measles followed, and spread slowly down the face, while the moaning of the child showed that consciousness was returning. The general condition became much easier for a time, but the breathing suddenly quickened and stopped, the rash disappeared, and the child expired.

Although high fever is not unknown in the measles of adolescence, yet a temperature of 109° is rare in that disease in childhood.

Early Diagnosis of Measles.-Dr. Koplik, Arch. of Pediatrics.—One of the most, if not the most, reliable signs of the invasion of measles has failed to receive due attention. That is the exanthematous eruption on the buccal mucous membrane. reaches its height just as the skin eruption appears and is spreading; when the skin eruption is at its efflorescence, the buccal eruption has begun to decline. There is nothing specially distinctive about the condition of the pharvnx or hard and soft palate in measles. The first twenty-four to forty-eight hours of invasion of measles is marked by suffusion of eyes, slight febrile movement, and perhaps cough or a little sneezing. At this period the skin eruption has not made its appearance, but on examining the mouth there may be a redness of the fauces. If now the buccal mucous membrane and the inside of the lips are examined, a distinct eruption of small, irregular spots of a bright red color is invariably seen; in strong daylight, in the center of each spot is seen a minute bluish-white speck, which is absolutely pathognomonic of commencing measles. They do not occur in the palate. number varies, sometimes requiring a careful search. spots are very different in appearance to sprue spots; the small specks retain their punctate character, and never coalesce. diagnostic test is of greatest value at the very outset of the dis-In scarlet fever the buccal mucous membrane is not affected; it is sometimes affected by simple aphthæ, but here the spots are not so bright red, and do not show the bluish-white specs. Rötheln, properly so called, has not the eruption on this mucous membrane. Commencing grippe in many cases resembles the onset of measles, but again this affection of the mouth is absent. In some cases of measles the spots are so few as to escape a casual examination; it is therefore well to carefully examine the mouth in a strong light from a window.

Tubercular Meningitis in Children and its Treatment .-Dr. C. E. Wheeler.—The importance of distinguishing a nontubercular form of meningitis which is often mistaken for the tubercular form, and is characterized by the early appearance of head retraction and the prolonged stupor stage is very great. The possibility of recovery from the true tubercular form, however, is proved by finding evidence of its previous existence in patients dying from other causes years afterward, as has been Two cases are recorded, one which was distinctly pal-'liated by homeopathic treatment though it ended fatally; and the other had been distinctly relieved and was still under treatment. Iodoform and zinc, met, are especially hopeful remedies, and also tuberculinum, belladonna, bryonia, hellebore, and apis. Dr. Madden recommends the use of only the higher dilutions, especially of calc. carb. He had seen cases presenting the appearances of tubercular meningitis recover under this drug. Dr. Dyce Brown also adds his testimony in favor of calc. carb. 30, and says he has cured cases of this disease with it. Dr. Hughes said he had never cured a case until he tried calc, carb, 30 on Jahr's recommendation, and that case recovered, and he has not lost a case since. Seven cases are reported by Dr. Arnulphy in the Belgian Homeopathic Journal, in which sulphur was the chief remedy. Dr. C. Wolston has found zincum 6 most useful, and recommends the hot pack as an excellent palliative adjuvant, but he has not seen a cure. Dr. Neatby mentions a case of recovery under iodoform 3x and a case where oxalic acid promptly relieved symptoms of meningitis.

Diphtheria and Diphtheroid Anginæ.—Dr. Vierordt. Berl. klin. Woch., draws attention to the importance of distinguishing between non-membranous anginæ due to the diphtheria bacillus and other forms of harmless angina. There are, in addition, some anginæ which, although resembling diphtheria, are not caused by Loeffler's bacillus. (1) True diphtheria: In membranous tonsilar diphtheria there was either an extensive, tough, adherent, whitish membrane, or small localized patches, in which the exudation was grayish-white in color and attached, either

tolerably firmly or loosely, to the surface of the tonsil. after the detachment of the membrane a whitish or yellowish spot or spots corresponding to the lacunæ were visible, but after the detachment of adherent membrane an easily bleeding surface was left. The diphtheria bacillus is infrequently present in typical lacunar angina. He gives details of eight such cases where there was no characteristic membrane, and yet the diphtheria bacillus was present in great abundance in the cultures His observations show that in the beginning and at other times in the course of diphtheritic angina a typical lacunar tonsilitis may appear absolutely indistinguishable from ordinary follicular tonsilitis. It usually occurs early in the case within the first three days, but the disease may remain lacunar through-Sometimes the diphtheritic process may start in the lowest parts of the tonsils and so escape detection. In cases of laryngeal croup there may be only a thin layer of exudation in the fauces, hardly recognizable. Necrotic tonsilitis, often limited to one side, may be due to diphtheria. (2) Diphtheroid without diphtheria bacilli: The author then refers to fifteen cases of angina simulating diphtheria where the bacillus was not to be found. There was no extension of the membrane to the nose or larynx, and no subsequent paralysis. Such cases may raise a suspicion of scarlet fever. The cases could not be distinguished locally or by their general symptoms from diphtheria or from socalled scarlet fever diphtheria. [As these cases are the same as the so-called true diphtheria except for the presence of the bacilli, and as the bacilli are found when there are no symptoms of angina present, the separation into diphtheria and diphtheroid is a distinction without a difference.—ED.] The author refers to relapsing diphtheroid anginæ. In some persons there would seem to be a tendency to the production of coagulation necrotic process in slight inflammations of the tonsils. (3) Necrotic anginæ due to the staphylococcus. Details are given of two such cases, but further information is wanted. The above observations have led the author to believe that diphtheria may occur in a lacunar form, and that after two or three days the characteristic membrane may appear. The term "lacunar diphtheria" is best applied to these cases. For membranous anginæ not due to the diphtheria bacillus the author would apply the term diphtheroid. Thus there may be a scarlatinal and non-scarlatinal

diphtheroid. Simple lacunar tonsilitis is the name used for ordinary follicular tonsilitis. In doubtful cases—laryngeal croup and extension to the nose—are in favor of diphtheria. The state of the cervical glands, of the urine, or of the fever are not of any real diagnostic value. It is well to isolate cases of lacunar angina, and during an epidemic of diphtheria they should be looked upon with much suspicion. A bacteriological examination should, if possible, be made. It is better that diphtheria should be diagnosed too often than that cases of true diphtheria should be overlooked.

Hysterectomy in an Infant.—La Clinique speaks of a hysterectomy necessitated by a sarcoma in a girl of seven months.

Lithiasis in Boys.—Dr. Schweiger, Wien. med. Woch., says that in Hungary children suffer not infrequently from stone. reports ten cases, the ages of the patients varying from two and a half to twelve years. In the matter of treatment he strongly advocates, for private practice, suprapubic cystotomy, which he states requires no unusual instruments and no special skill; in these respects it stands to lithotrity as does tracheotomy to intubation. He finds the suprapubic operation very easy in children, and even safer, though the time in bed is somewhat longer than after itholapaxy. The bladder, which heals very readily in young subjects, should be at once sutured completely with silk, no drainage being adopted. The only special source of difficulty is the great reflex excitability of the bladder in children, which may prevent its being properly distended; a low insertion of the peritoneum may also complicate the operation. The author has had no trouble with the stitches in any case; he does not think they should ever require removal. Stones are sometimes impacted in the urethra, whence the simplest mode of dislodgment is a prolonged warm bath, which is often effective alone. In one of the author's cases a periurethral abscess had formed, which, when cut down upon, was found to contain the stone. In another the concretion was removed by urethrotomy, and in a third it was extracted from the cavernous urethra by suprapubic cystotomy. In both the latter cases retention and dribbling had persisted for some days, and the bladder reached nearly up to the umbilicus.

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MENOPAUSE.

By A. B. DAKE, M. D.

THE word menopause, as commonly used, is limited in its definition and does not cover the scope of this paper. I much prefer the term "change of life," as used by the laity. The change occurring in the system at this time affects the physical, mental, and domestic life of the patient for a much longer period than is given by the majority of authors, and I differ from them on that point as well as many others.

I will not quote from books what you are already familiar with, but will try and give you some personal conclusions based upon close observation and questioning of patients at that period of life. The menopause may and frequently does occur as early as the twenty-fifth year, and as late as the sixtieth year. Instead of the system adjusting itself to the change in one or two years, as so many teach, it takes from two to ten years, according to the age and vitality of each case. The younger the patients, the less liable are they to deep-seated and fatal diseases, owing to the greater power of vitality and nervous energy in the young to ward

off disease. On the contrary, the change occurring late in life, when vital energy is more or less exhausted, there is greater tendency to fatal results, such as exhausting hemorrhages, due either to lack of tone of the vascular or muscular tissues or tumors and carcinomatous growths, which are so liable to grow at this time. If there is a constitutional tendency to morbid action, it is liable to attack the weakest organ. Hence many die of diseases of lungs, liver, or some of the varied scrofulous affections. There is a tendency to take on inflammatory diseases at this time, and a rise in temperature at slightest provocation.

I have made a practice of using a clinical thermometer in cases where hot flashes have been marked, and the majority of cases show an elevation of temperature from one degree to one and a half degree, without any perceptible cause further than extreme nerve waste.

At no other time in a woman's life do the nerves play as important a part as at the time of the menopause. And years elapse before the nerves and circulatory system become quiet and settled to the new action of the pelvic organs. The nervous influence which prompted the catamenia is still in force and produces reflex pains in the head, back, pelvis, bladder, and rectum.

These symptoms are often misleading both to patient and physician. The patient broods upon her condition, which she fancies will prove fatal, until insomnia and nervous prostration, melancholia, and insanity result. Too rapid suppression of the uterine function effects the portal circulation, causing constipation and hemorrhoids with their accompanying discomforts. At each visit the patient makes her physician she brings some new complication, real or imaginary, until the doctor becomes confused and weary of well doing.

To treat the mental condition is as necessary for the patient's comfort as to treat the physical alone. The morbid irritability arising from undue activity of the mind occurs at the expense of the body. The perspiration following the hot flashes is a safety valve for the system, freeing it from

poisonous accumulations and saving the internal organs from disease.

In fact, all the organs are liable to be weakened, and soon as one recovers from an abnormal condition another will start up, and sometimes the whole are deranged at the same time. The vision is perceptibly altered, and is hard to be corrected, owing to the rapid change which is continued for an indefinite period. In a household where there is a patient undergoing this metamorphosis great patience must be exercised by the physician and every member of the family, for you never know when there is going to be a change of harmony; what pleases "her majesty" to-day is wrong to-morrow, and, as I said before, you must exercise as much skill in treating the mental as the physical ailments. The patients should be cautiously impressed with the truth that dangers await them. At the same time, they should comprehend the fact that with proper care they can, and usually do, escape with comfortable health. Unfortunately it often happens they give little or no intelligent attention to the subject until serious disturbances have occurred which are hard to cure. On the other hand, it is almost impossible to argue them out of their insane ideas that they are going to die.

A vaginal examination should be advised in all cases as often as every three months, to be sure that no disease of the pelvic organs exists. The return of the menses after a period of several years is to be taken as a warning of some serious condition existing, and great care should be used in examining to find the cause. The treatment of patients at time of menopause depends upon the conditions and characteristics of individual cases, climate, marital and home life, and constitutional dyscrasias and idiosyncrasies. The following are a few hints applicable to all:

As little waste of nervous energy as possible.

As few cares and responsibilities as possible.

A cheerful home and companionship.

Moderate and daily exercise, but not to exhaustion.

Frequent bathing to free the pores of poisonous accumulations.

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All excretions should be free and regular.

Massage where vitality is low and no exhausting hemorrhages have occurred.

Change of climate or scene where there are unhappy home surroundings.

Medicines should be selected for each case, as different symptoms appear.

PAINLESS LABOR.*

PHOEBE J. B. WAIT, M. D.

NE of the most unexplainable mysteries of the dealings of a merciful God with his creatures to my mind has ever been the so-called curse pronounced upon womankind as recorded in Genesis iii. 16, "Unto the woman he said, I will greatly multiply thy sorrow (pain) and thy concep-In sorrow thou shalt bring forth children." Without the advantages of Greek and Hebrew teachings, the vast majority of civilized mankind has, like myself, been left entirely at the mercy of translators who have never failed to keep up the testimony which relegates the mothers of the race, in an ever-increasing ratio, to the pangs of perdition. All through the Old Testament scriptures is repeated, scores of times, anathema upon a childbearing woman; while in almost parallel columns occur a great number of passages condemning to humiliation and ostracism such women as for one reason or another do not become mothers. Our Scriptures, as translated for us, have kept the women of the civilized world forever between the upper and the nether millstone, and the wonder is they have not been wholly exterminated. On the one hand, we read, Jeremiah vi. 24, "Anguish hath taken hold of us and pain as of a woman in travail," and, on the other, Genesis xxix. 32-33, "Surely the Lord hath looked upon my affliction. The Lord hath heard that I was hated, therefore he hath given me this son." Again, Psalms xxviii. 6, "And

^{*} Read before the New York County Homeopathic Medical Society.

fear took hold upon them there and pain as of a woman in travail," or, Luke vii. 25, "Thus hath the Lord dealt with me in the days wherein he looked on me to take away my reproach among men." Again, Micah iv. 9–10, "For pangs have taken thee as a woman in travail. Be in pain and labor to bring forth, O Daughter of Zion, like a woman in travail," and its antithesis, Genesis, "What wilt thou give me seeing I go childless?"

These few are an epitome of a long list, but they cover the entire gamut: sorrow, fear, anguish, pain to the women who go to the right: but affliction, reproach, hatred, humiliation, if they turn away to the left. Is it any wonder if, in the language of the Psalmist, she sometimes in bitterness of spirit cried out, "Whither shall I fly?" To the readers of Scripture such teaching has had its effect upon the mothers of Christendom, slowly but surely leaving its impress upon mind and body, until it is impossible to tell what different conditions might have prevailed had not all Christendom believed and thought and taught as it has done for centuries. That a loving father ever condemned the mothers of the race to "bring forth children in sorrow" no one can believe, who, on the other hand, reverently believes this antithesis, "Like as a father pitieth his children so the Lord pitieth them that fear him." Two attributes so absolutely at variance cannot belong to the same being, especially when that being is a beneficent God. Without stopping to determine, which we are not able to do, the origin of the "pain and sorrow" of childbearing, which has come as a terrible legacy down through the ages to motherhood, let us not forget that evil has been in the world and that whatever is wrong (and surely anguish and sorrow and fear and pain are wrong) is an outgrowth of evil.

An Almighty Father may permit evil to exist, but it is not a part of his plan nor can he ever approve it. No Christian woman in her right mind could adore a God who, from the beginning, had cursed her as we have been hoodwinked into believing we have been cursed; and no loyal son of a faithful mother could any more believe it than

could she who bore him. Nevertheless, the idea was abroad, and generation after generation looked into the darkness, not knowing where to find the light, and there seemed to be no one to suggest turning about.

In 1846 sulphuric ether was first used to prevent pain in a surgical operation by Dr. Morton, a dentist of Boston. The news of the discovery reached London on December 17, and the 19th it was employed by an eminent surgeon in performing an operation. Sir James Y. Simpson, professor of midwifery in the University of Edinburgh, appears to have been the first man in Great Britain who had the courage to apply the principle of anæsthesia to allaying the pains of labor, though it had been experimented with somewhat in America prior to his use of it. It was he who discovered the anæsthetic properties of chloroform in 1847, and introduced it as a safer and more certain agent than ether in labor. It is almost too much to believe that the use of anæsthesia in labor was met by torrents of opposition, and only the most hardy physicians were willing to confess to its use, the confession being tantamount to openly defying the decree of the Almighty. "In Scotland," says Andrew D. White, "Sir James Y. Simpson was met by a torrent of opposition. This hostility flowed from an ancient and time-honored belief in Scotland."

As far back as 1591 Eufame Macalyane, a lady of rank, being charged with seeking the aid of Agnes Sampson for relief of pain at the time of the birth of her two sons, was burned alive on the Castle Hill of Edinburgh; and this old theological view persisted even to the middle of the nineteenth century.

"From pulpit after pulpit Simpson's use of chloroform was denounced as impious and contrary to Holy Writ. Texts were cited abundantly, the ordinary declaration being that to use chloroform was to avoid one form of the primeval curse upon woman."

Every woman, however, who had once experienced the blessed relief incident to the use of ether or chloroform in delivery would no longer do without it, and doctors soon found that they must use an anæsthetic for their patients or abandon the practice of obstetrics. This settled the theory of the primal curse and practically banished it as well, because it did not require deep learning to observe that no inflexible decree of the Almighty could be made to yield by a few whiffs of a simple fluid which could be carried in a tiny vial in a man's vest pocket. It was left then for Dr. Morton of Boston and Sir James Y. Simpson of Edinburgh to reverse the old order of the time-honored curse, and to establish a new order whereby the pangs of travail became practically obsolete and childbearing was robbed of its terrors. Occasionally some thinking mind has attempted in other ways to overcome the supposed inevitable, and some advance was made through keeping pregnant women upon a certain diet during the entire period of gestation. The theory was-and not without reason—that a long process of rigid hygiene tended not only to overcome the density and tension of the maternal parts, but at the same time retarded the development of the bony framework of the fetus, thereby rendering its passage through the pelvic canal less aggressive and painful. We have read of some tolerably successful experiments upon this line. The diet employed was largely fruit and nuts, vegetables which had not much starch; a little bread and fish, but no meat; much attention was given to baths and exercise. A woman of our profession thought she had solved the problem for herself, when, after the above regimen during pregnancy, she was delivered without pain and so rapidly that assistance reached her only after the delivery of the child.

I am not aware that children born under this regimen do not thrive, but there has always been a doubt in my mind whether full justice is done to the child in depriving it of calcareous materials prior to birth. We all know that one sparrow does not make a spring, but one experiment of the kind just recited will set people thinking and, once in a while, will find those who will seek to repeat it. It is asserted that children born after the prenatal acid-fruit and

leguminous diet of the mother have but a poor bony framework with which to begin life, having been robbed of the limy products through a sort of starvation process. If this be so, and such was the claim of its advocates, but few would have the heart to advise it; because even an unborn child has rights which should be respected; and painful delivery, with its ancient respectability, ought not to be a bar sufficient to prevent properly nourishing the fetus in utero.

Having this predilection, I have never encouraged patients to try the acid fruit experiment, and am not therefore prepared to speak from personal knowledge of its results. One point which has staggered civilized people has been the well-authenticated fact that the women of savage and barbarous tribes never made any serious account of childbearing. The nearer to nature women lived the farther apparently were they removed from the curse. North American Indian women, who were always the burden bearers, if taken in labor when on the march stopped at any convenient stream or spring while the other members of the party went on. Here she would be delivered of her child, would wash and dress it, bathe herself, and then fixing the little bundle upon her back hasten on to meet her husband and the rest of the tribe as though nothing had happened.

This, we read, is substantially a history of childbearing outside the pale of civilization, and how can it be reconciled with the primal curse? The uterus is a hollow organ analogous to other hollow organs of the body. These others, the heart, stomach, bladder and intestines, evacuate their contents in an absolutely painless manner unless pathological changes have taken place, and this, in our judgment, should be the history of the action of the uterus in expelling its contents. Moreover, the anatomical structure of the uterus shows it to be without cerebrospinal nerves above the cervix, the fundus and body being supplied from the sympathetic system through the hypogastric and cervical plexus, and so meager is the sensitive

nerve supply to the cervix that some of us have seen the cervix amoutated without the use of an anæsthetic, the patient apparently comfortable both in mind and body. From whence comes the pain? The action upon the cervix incident to delivery takes place slowly and consists in a gradual softening process, until a short time prior to delivery when, as by a miracle, the entire cervix is absorbed or swallowed up into the body. But so kindly does nature handle this cervix that, even with its supply of cerebrospinal nerves, a woman is not conscious of the action going on within her body, as no pain whatever is experienced. We recall distinctly a lecture delivered many years ago by a very learned man upon the subject selected for this paper. He, with much seriousness, assured his hearers, who were all women, that "there was no such thing in the world as labor pain," because "such a thing was impossible." Had he have said, "there ought to be no such thing," he would have come nearer the fact, for when there is no need of it for one class of women, there ought not to be for any class. If the simple women of the forest are. exempt, by the same token all the daughters of Eve should enjoy a like exemption. The same organs, muscles, bone, blood, nerve, and sinew are in their bodies as in ours, and all are governed by corresponding rules. The most expert microscopist could not discover whether slides prepared from these various tissues were from the body of a North American Indian woman or a Fifth Avenue millionaire.

In twenty-seven years of more or less obstetrical practice it has not been my fortune to meet a single absolutely painless labor, and my experience coincides with that of a large proportion of those in our profession; but that painless labors do occur is undoubted, and that what has happened once may happen again goes without saying. Two women, each of undoubted integrity, and whose names are known to many, have, each for herself, described a painless labor in her own experience, the simplicity and beauty of which, as told to me, were never excelled by that of any dusky daughter of the forest. There was no "sorrow or

anguish" at any time, and the action going on in the uterus was only made known by a feeling of tenesmus during the second stage. One of these women, who lived in a nearby town in New Jersey, felt so perfectly well after the child was washed and dressed, that she herself dressed and went down into her garden, where she was gathering flowers when her husband reached home from his business in New York. Of the other I do not recall details, as it has been some time since it occurred, and I am dependent upon memory to report the case; but it did not differ essentially from the first, and neither of these women had taken any especial diet or treatment during pregnancy. recently it has been my good fortune to interview a woman who has had two successive labors, neither of which developed a particle of pain. Her first labor occurred when she was thirty four years of age, but was short and ideal in every way, no injury occurring to the external parts. The second, three years later, was a repetition of the first, the only sensation, she assured me, being a feeling of straining which she located in the rectum. Her doctor was so sure that he understood his business that he was going to leave his patient for a while without examination, when at the rather urgent request of the nurse he reconsidered, and had only time to receive the head as it passed the isthmus. each of these cases the patient assured me there was no sensation but of tenesmus, and there were no subsequent sequelæ of any sort. The woman is rather below medium height, but is well shaped and robust in size. Sometimes an exception proves a rule, and if in all Christendom these cases referred to were the only exceptions, they are enough to prove that woman is not and never was under a curse as mothers of the race. A wise Providence, which planned the female pelvis with all its intricacies, and set bounds and metes to it which are practicably as unalterable as the eternal hills, also planned the fetal head with its constant parity to the adult pelvis. The hollow organs whose physiological functions are to expel their contents without pain to the individual were never designed to cause suffering of any sort when in health, and all suffering arising from any one of these organs, whether it be the heart, the stomach, or the uterus, is as contrary to the will of a merciful Heavenly Father as cruelty toward children is contrary to the instincts of earthly parents.

What is most surprising, is that the so-called scientific world has gone on believing such a libel upon our Creator and upon the mothers of the race without question. My hope in preparing this paper is to gather information upon the subject from any who are similarly interested, and at some subsequent date to be able to record more testimony for my own benefit as well as that of my colleagues in this society. If Physiology or Hygiene or Therapeutics hold the keys which unlock such royal treasures to womankind -they are ours to command. If heredity or environment have been responsible for these centuries of evil, may not the breadth and depth of the altruism of the nineteenth century open ways to better environment and truer living, whereby coming generations of women, no longer forced to drink of the chalice of gall and wormwood, may accept the royal privilege of honorable motherhood with joy and gladness as the Creator designed she should?

CHRONIC UTERINE HEMORRHAGE CURED BY DULL CURETTE AND TINCTURE OF IODINE.

BY E. M. HALE, M. D.

THE following case illustrates the inutility of medical treatment and the inefficacy of mild intra-uterine application. Mrs. T., aged thirty. Four months before I saw her the menses lasted ten days and were very profuse. The next menses lasted two weeks, leaving but a few days interval before the appearance of the next period. Since that time the hemorrhage has been continuous, nearly two months. She had been under the care of two physicians; one relied entirely on medicinal treatment without any

beneficial results. The other physician gave internal remedies and made applications of iodine by means of a cotton-wrapped probe every three days for two weeks, with but slight arrest of the hemorrhage, which returned when the applications were suspended. She then called me, and I made an examination. The vagina and cervix appeared healthy, but pale. The uterus was enlarged and the vaginal vault tender on pressure. The blood flowing from the uterus was dark. The cavity measured four inches, ustilage 6 was prescribed gtt. x every two hours. After three days no favorable results. As this was the time in the month when the menses usually appeared, I thought the failure of the medicine might be due to that, so after waiting three days the drug was resumed but with no benefit.

I then used Thomas' wire curette as thoroughly as possible and got away some evidences of cystic degeneration. The cervical canal was dilated nearly half an inch, which allowed the curette free access. Then the cavity was carefully wiped out, and through Butte's spray syringe, one dram of comp. tinc. iodine was thrown in. The vagina was packed with dry absorbent cotton. At the expiration of twenty-four hours this was removed. The cotton was not bloody, only stained with the iodine.

There was no hemorrhage after this. After three weeks the menses appeared, nearly normal, lasting but six days.

Twenty-eight days after, the menses, and lasted but five days. She has regained her color and strength, and appears in excellent health.

Except in very severe cases, I have found the wires or dull curette, followed by a spray of iodine, to be all that is needed.

CONSTIPATION.

BY E. B. KAPLE, M. D.

Na clinical lecture delivered at the Central University of Kentucky, Professor Thomas H. Stucky, speaking of digestion, says: "No function of the human body is so universally abused as this one, nor bears so important a relation to the health and well-being of the individual. It is the starting point of many maladies, bearing the burden of every disease and the responsibility of human life." Without a proper digestion we pave the way for innumerable disorders and lay the foundation for ill health and disease.

Proper performance of the digestive function being then so essential to perfect health, and no argument being necessary to prove that digestion and assimilation cannot properly take place if constipation be present, the practical importance of a full and free discussion of this subject is at once apparent.

Believing, as I do, that the reading of any paper is less beneficial than a free discussion of the same, I have prepared this with more of a view to draw out discussion than to present a complete or thorough consideration of the subject.

Especially is this true of the treatment, and I sincerely trust that my efforts will be so far appreciated that my views may be given, if not a rough, at least a thorough handling.

Before any consideration of this subject is possible, it is necessary that we understand what I mean by the term constipation. In looking over literature bearing on this affection, I have been greatly surprised at the incompleteness and variety of its definitions.

So long as we accept such definitions as that given in Osler's work on Practice—"retention of fæces from any cause," there is sure to be more or less difference of opinion as regards the effects of constipation on the general health.

Such a definition does not seem to me at all complete, nor does it express my idea of the true significance of the pathological condition under consideration. I therefore desire it understood that when I refer to constipation, I mean a condition "in which the intestine fails to readily expel the excrementitious matter which it contains, at intervals sufficiently frequent, and in a mass of suitable consistence to insure the individual against detriment from waste and decomposing material." Constipation is therefore decidedly a relative term, and a certain individual might comply with the requirements of Osler's definition in not having a movement in thirty-six or forty-eight hours, perhaps longer, yet should that individual be so constituted as to suffer no "detriment from waste or decomposing material," I make the contention that it would not be a case of constipation.

By forcing all cases to come under the conditions of my definition, we shall greatly reduce the number of patients who answer "yes" to our inquiry if they are constipated, and we shall limit them strictly to those cases wherein it is a distinct pathological condition of great importance. Notwithstanding this limitation, we will find enough cases remaining to make a formidable antagonist, even in numbers. It is indeed not only of great frequency at the present time, but is daily becoming more prevalent.

The cause of this increased frequency may profitably occupy some of our attention. In the opinion of the writer, it is principally due to the fact that it is a condition so little regarded by most people that no attention is given it until some more remote symptom, depending thereon, causes them to consult their physician. He may pay no attention to the real cause of their trouble, or, if so, gives a pill or two to "clean them out," at the same time admonishing them to keep the bowels regular hereafter. The patient goes away perhaps impressed with the seriousness of that remote symptom, but not at all as to its dependence on constipation.

It is a fact that pure neglect is one of the most frequent

causes of this trouble, and ignorance or indolence the usual cause of the neglect. If the profession would dispense to the public more good advice and information, and less medicine, by preventing disease it would do more good than it ever has done in attempts to cure.

Let it be emphasized that the number of constipated creatures is daily increasing and that the medical profession is to a great extent the passive (active sometimes) cause of this increase.

Kindly permit me to call your attention to the following ætiological factors and their relations to the trouble under consideration:

Heredity, age, sex, habits of life, disease of the intestines, and diseases more remote from the seat of manifestation.

As regards heredity, very little can be said, though certain it is that this affection seems frequently to be a family trait. Of just what this family predisposition consists we cannot say, yet its importance as a causative factor should not be lost sight of, and it should furthermore be the physician's duty to caution any member of such a family against those avoidable causes, which, acting on this predisposition, are in consequence much more effective.

There is no period in life during which an individual is exempt from this condition.

From the newly born babe to extreme old age does it prevail. In infancy is it especially annoying, in fact, dangerous, while in old age those very conditions which most frequently provoke the trouble at the same time render its results the more serious.

It is a fact, well known to the medical fraternity at least, that the female, much more frequently than the opposite sex, suffers from this affection. Indeed, that extremely cynical and sententious definition of a woman, "a constipated thing with a pain in its side," while perhaps not extremely reverential, nevertheless seems at times almost to be warranted. To find a woman with a regular bowel is somewhat the exception. This extreme prevalence, together with the fact that so many are apparently healthy

notwithstanding this condition, has led many to underrate its seriousness.

Is the mere fact that most women lead more or less of a sedentary life a sufficient reason for this frequency of constipation among them? It seems evident on some consideration that there are numerous other reasons for this prevalency.

One, little thought of, perhaps, is the want of suitable closets for the moving public. It may seem, at first thought, that this would affect man as well as woman, yet this is not so. When nature calls to a man, he hustles and finds a suitable, if necessary an unsuitable, place, while woman, on the contrary, yields to that false idea of modesty, and waits till she gets home or to some other distant place. The word false is used advisedly, for the simple reason that I do consider any so-called modesty that stands in the way of an individual's health to be decidedly false.

This idea, whereby nature's calls are neglected till some more favorable (?) time, causes repeated stimulation of the intestine from overdistention, as a result of which its muscular activity is exhausted and an atonic condition produced.

Menstruation may be another provocative factor. During this period more or less congestion and engorgement of the pelvic viscera are necessarily present, in which the intestines and other nearby organs to some extent are involved, more especially the rectum.

It has, by experimentation, been conclusively proven, that the condition of the circulation in the intestine greatly influences peristalsis. This being true, it seems clear, to my mind at least, that the periodical congestion incident to menstruation, acting on a woman predisposed to constipation, may very easily prove a most effective cause. In pregnancy we also get a venous congestion of the rectum, due to the increased flow of blood to the pelvic organs, which condition is later rendered still more pronounced by the pressure of an enlarged uterus.

This enlarged organ may indeed serve of itself as an impediment to the passage of the intestinal contents. Moreover, as a result of repeated pregnancies, the abdominal wall becomes weakened, the aid of the voluntary muscles of defecation being hereby materially impaired.

According to the teaching of physiology, the rectum is empty the greater part of the time, and the desire to empty the bowel is a result of the fecal matter contained in the rectum acting as an excitor of reflex action. If our experience in making vaginal examinations, without the patient having previously been instructed to thoroughly empty the bowel, is any criterion, the statement that the rectum is usually empty is certainly to be doubted.

If, however, experiments should demonstrate the rectal mucous membrane in woman to be less sensitive than in man, it would explain why we so often find the rectum a storehouse for fecal matter, and would also offer a reasonable excuse for this prevalence of constipation.

Andrew F. Currier, in an excellent article in the New York *Medical Journal*, on the relation of constipation to diseases of woman, says "the sensitiveness of the rectal mucous membrane varies greatly in different individuals, and in women it seems to be less acute than in men.

He also says, "In my experience the rectum of women is rarely free from fecal matter, except after particular preparation."

While many diseases tend to produce constipation in either sex, yet certain it is that women, as a result of anatomical differences, are more liable to those diseases. A sedentary life then, embracing, as it does, in its results a deficient oxidation, thereby impairs the contractile power of both voluntary and involuntary muscle fiber, and is consequently a very common cause of constipation, yet it falls far short of explaining the special frequency of this trouble in women.

On the other hand, a life of extreme activity and muscular exertion may under certain conditions lead to the same

result, but by a different process. Any occupation producing excessive and long-continued perspiration, may, in fact, by withdrawing fluids from the body, make necessary an increased absorption from the intestinal contents, the fæces becoming, as a result, dry, hard, and difficult of expulsion.

As regards the effects of diet, there is a great difference in individuals. That which in one person may have a constipating effect, may in another produce a directly opposite effect.

I believe, however, that constipation is more often produced by what people do not eat, than by what they do eat.

The prevailing idea of the present time seems to be to eliminate from our food stuffs everything which cannot be readily dissolved and taken into the system. People go to their clubs, into the café, to their hotels, etc., order a meal composed chiefly of tea or coffee or milk, bread or some substitute made of flour, and containing little else but starch, a small piece of meat, few or no vegetables, a large dish of ice cream with something else equally thin for dessert, then leave the table thinking what a fine meal they have had. By the time that food has passed half its way through the small intestine it is completely absorbed, no residue is left, and consequently nothing to stimulate peristalsis.

But it must not be forgotten that an opposite diet is capable of producing a like result by leaving too much coarse, dry residue, which is expelled only with great effort.

The efforts to relieve temporary attacks by the repeated employment of purgatives often lead to habitual constipation, and I regret to say that this treatment is being encouraged by a great many members of the medical profession. While this affection does not as a rule receive the attention it deserves; yet there are many individuals whose sole ambition seems to concentrate itself in the effort to "keep their bowels open." It is this class of people who are of more value to the infant (?) pill making industry than any protective tariff ever can be.

The repeated use of powerful cathartics will convert the most well-behaved, regular, and obedient bowel on earth into a sluggish, constipated nuisance.

Any stimulant to continue effective must be administered in increased quantities. This is equally true of drugs given to stimulate the activity of the bowels. It is moreover generally true of people that whenever they can find someone to do work for them, they do not do it themselves. This peculiarity of individuals is usually true of the various organs of the body. If intestinal peristalsis is moved to activity by drugs, instead of as the result of natural reflex actions, then there is no necessity for the latter, and after a time they become weakened from non-usage.

A cause, exceedingly prevalent, yet rarely mentioned, is the common habit among this hustling American people of attempting to fill their heads while emptying their bowels. I refer to reading while at stool. Anything that impairs the activity of the voluntary muscles of defecation, tends to produce constipation; and I do not believe one's mind can be occupied both with reading and directing those voluntary muscles when and how to act without neglecting one or the other.

Prolonged mental labor by weakening the nervous forces and being usually accompanied by insufficient physical exercise is frequently a provocative factor.

Inflammatory diseases of the intestine may in several ways produce the trouble.

First, the normal circulation in the bowel is interfered with.

Secondly, chronic or subacute inflammations may result in an atony of the mucosa, as a result of which the intestinal secretions are disturbed, the sensitiveness of the membrane impaired, and peristalsis less actively stimulated. Certain conditions, such as chronic dysentery or ulcerative colitis, may result in a contracted bowel, thereby producing a very obstinate form of constipation. Osler says this latter condition, which he terms "spasmodic constipation," is frequently seen in the very aged with no evident cause.

He also remarks its frequency among protracted cases of hysteria, especially among females suffering from some uterine trouble. Perhaps this will be a good place to say just a word in regard to hysteria. Flatulence and constipation being such frequent accompaniments of hysterical attacks, has led me to wonder if what I shall call a "sympathetic hysteria" does not exist. We know that certain functional disorders of the general nervous system produce certain disturbances of the motor, sensory, vasomotor, and mental apparatus, which we designate hysteria. It is also well known that a neuropathic disposition is usually the foundation of these cases. Now what I mean by "sympathetic hysteria" is this: Certain disorders of the sympathetic nervous system may exist, independent of any trouble involving or evidencing itself through the cerebrospinal system, which may make its presence known by the way of the various abdominal and pelvic plexuses by just such symptoms as flatulence with tympany, constipation, etc., without the more general symptoms of an ordinary. hysteria. May not these abdominal symptoms be indicative of a hysteria involving only the sympathetic system?

The action of foreign bodies, tumors, scybala, fecal impaction, strictures, etc., in producing obstinate constipation is too well recognized to merit more than mentioning.

There are numerous affections of parts of the body more or less remote from the intestinal tract, in which, nevertheless, this symptom of constipation is frequently a troublesome and at times a dangerous one.

Normal evacuations depending on a normal peristalsis, and this being the result of reflex action depending for its perfection on certain nervous plexuses in the intestinal wall, together with a healthy action of the general nervous system, no extended argument is needed to demonstrate the relationship between constipation and such affections as hysteria, neurasthenia, melancholy, insanity, and many central nervous disorders.

It is such a common symptom in anæmia or chlorosis, that no less an authority than Sir Andrew Clark was led to

believe it the actual cause of chlorosis. The general muscular weakness, impoverished condition of the blood, and the nervous disturbances all peculiar to these complaints, are certainly sufficient to account for a constipation, but, whether it be cause or effect, the important point to remember is that its removal in these cases is usually followed by signs of improvement.

The great majority of fleshy persons become so from over-eating, combined with lack of exercise. Add to this the fatty infiltration in muscular structure so common in these persons, and the retardation of the movements of the diaphragm resulting from large masses of omental fat, and the relation of obesity to the disorder we are considering is at once apparent.

Any disease interfering with free secretion of bile robs the intestine of a most active peristaltic stimulant. Hence the frequency of this disorder in such diseases as catarrhal or obstructive jaundice, hepatic cirrhosis, atrophy, etc. Gastric indigestion, or dyspepsia, by allowing food not properly acted upon to enter the intestine, may be a cause.

The constipation of diabetic patients is well recognized, the excess of water eliminated by the kidneys, necessitating the replenishing the system by absorption from the intestinal contents. So, in the same manner, may excessive lactation produce this trouble.

Certain cardiac disturbances, by disturbing the circulation, may provoke a sluggish bowel. Asthma, bronchitis, or emphysema interfere with proper oxygenation of blood. Contractile power of muscle fiber depending on a supply of properly oxidized blood, these diseases are frequently accompanied by constipation.

The symptoms of the disorder, such as fullness in the rectum, flatulence, colic, foul breath, coated tongue, anorexia, debility, mental depression, etc., are known to all.

It is clearly evident that constipation may lead to (if persistent) such conditions as piles, ulcerated colon, perforation, enteritis, or occlusion, and while these are serious enough, I do not think the importance of a careful con-

sideration of constipation depends so much on these as on those chronic, insidious, and remote maladies, that so often perplex the physician and finally end in destroying both his and the patient's confidence in medication.

Osler says that "most persistent constipation may exist for even months, with fair health," and that "all kinds of evils have been attributed to poisoning by resorption of noxious matter from retained fæces—copræmia; but it is not likely that this takes place to any extent."

As regards fair health with constipation, accepting a fair definition of the latter, I do not believe that it can exist for any considerable time without being decidedly detrimental to the health of the victim. I am also firmly convinced that resorption does take place, and that it is the principal cause of such symptoms as languor, foul breath, furred tongue, anorexia, headache, and many others. I believe that, could we eliminate constipation from the list of causative factors, we would thereby reduce the number of cases of headache fully as much as we would by removing such well-known causes as eye strains, nasal irritations, or pelvic disorders.

Many a poor victim has been nearly scared to death by being told he had "heart disease," when nothing under heavens was the matter but constipation. Pressure of gas in a distended bowel interfering with action of the diaphragm, obstructing venous circulation in the viscera and thereby causing symptoms of cardiac distress, dyspnæa, vertigo, and perhaps slight ædema of feet and ankles.

It is often difficult in cases of dyspepsia to decide whether the accompanying constipation be cause or effect. It is probably frequently the latter; but one can readily see how pressure of a distended colon on the duodenum could interfere with the digestive function and ultimately lead to dyspeptic symptoms.

Pressure of a distended colon may also result in irritation of the urinary tract, neuralgic pains in the groin, ovary, testicle, and lower extremities, while an overloaded sigmoid may cause neuralgia of the sacral nerves.

Many cutaneous affections are often directly dependent

on constipation; as psoriasis, eczema, prurigo, erythema, etc.

To decide the relationship between pelvic disorders and constipation is very difficult many times. Yet the frequency, indeed the almost universal coexistence of these two troubles, renders the decision an important one. Certain it is that the vascular disturbances produced by constipation are sufficient to produce many pelvic troubles, and morever that the relief of the former is often followed by the disappearance or improvement of the latter. And, whether cause or effect, its presence is always a serious obstacle to the cure of these disorders.

The diagnosis of constipation would at first thought seem a very simple procedure. But the physician who, as soon as he discovers that his patient does not have a movement at least every other day, immediately says "constipation," and then runs over his list of remedies for the relief of this condition, makes a grievous mistake. If the patient does not suffer any evil consequences from this peculiarity, it is not in his case a pathological condition, is not constipation, and demands no treatment. If it be constipation, no treatment can be intelligently carried on until the cause is ascertained. No diagnosis is complete unless these two points are carefully considered.

That old saying, "an ounce of prevention is worth a ton of cure," was never more appropriately used than in reference to the treatment of this condition. The doctor who impresses on the mind of his patient the importance of plenty of good out-door exercise will, by prevention, cure more cases of constipation than he ever will by drugs. But the great trouble in the treatment of these cases is to persuade your patient to persevere in the course you lay out for him. If you can accomplish this, I believe you can cure most cases not due to malignant growths or intestinal obstruction other than fecal. Treatment naturally divides itself into the following methods: hygienic, mechanical, electrical, operative, and medical, the first and last being in my opinion the most generally useful.

Let all habits be systematic. Have regular hours for exercise, for meals, and for attending to nature's calls. the diet be regulated according to the needs of each individual, but plenty of fruits and vegetables, with an abundance of water can always be recommended. exercise in open air if possible. Horseback riding is an ideal form of exercise for this complaint, and is always to be advised when practicable. A form of exercise nearly as effective, and free to anyone, is walking. Massage comes under mechanical measures. It is, however, simply muscle exercise, and I do not believe the best system of massage treatment ever proposed is as efficacious in the treatment of constipation as a good horseback ride every morning. It is a treatment, however, which appeals to a certain class of female patients more than ordinary exercise, and is also a great aid in treating that class of men who have more time than brains. Where exercise cannot or will not be taken massage is a most valuable substitute.

Injections and suppositories in some cases may be of use, but to rely on them for cures will, I believe, usually end in disappointment. The galvanic current may often be advantageously used. In those cases due to malignant troubles or to obstructions, operative treatment is the only method at all assurative of success.

In the medical treatment, we, as homeopathic physicians, possess a great advantage over members of the dominant school. It is needless for me to attempt to review a list of remedies and indications, as these can be found in any textbook. The use of any violent cathartic is to be deprecated. It will never cure but often produce the trouble.

I desire to mention a combination that I have found very useful in certain cases. It may bring down on my head the wrath of some of my hearers, on the grounds that it is unhomeopathic. Discussion is what we need. Perhaps this will stimulate it.

Be that as it may, the compound is made up of aloin $\frac{1}{6}$ gr., belladonna $\frac{1}{6}$ gr., and strychnia $\frac{1}{60}$ gr. Whether each constituent acts independently, the aloin flushing out the

lower bowel, the belladonna relieving the venous congestion, and the strychnia increasing peristalsis by toning up the muscular and nervous structure, or whether they unite to form a compound of a new action peculiar to itself, I cannot say, but whether it be homeopathic, allopathic, or "what not," it is a happy combination, gives good results, and I recommend it unhesitatingly.

DYSMENORRHEA.*

J. C. NOTTINGHAM, M. D.

THE classification of forms of dysmenorrhea and the ætiology and pathology would, as I believe, comprehend as many variations as subjects, constitutions, temperaments, and habits of life, including improper hygiene; and this last covers a multitude of technicalities in life—as clothing suited to the requirements of the individual and the vocation, the home life, the necessities and habits of exercises, gymnastics, the diet, indulgences, and amusements. "Each individual case has a pathology peculiar to itself." This is not exactly true, yet the variations are so great that it becomes necessary to "make as close an investigation of each case as if it were the only one we ever saw," for purposes of treatment.

Long experience does enable us to differentiate between them more readily than with first cases. But so varied are the conditions (pathology) and the causes (ætiology) that it is as impracticable to assign a name for the pathology and ætiology of dysmenorrhea with rational advantage, as it is in the conditions called "rheumatism," "dyspepsia," "nervousness," "impure-blood," etc., to which pathologists have endeavored to assign pathological nomenclature for many generations; and will fail in the future as in the past, until the assignment of name is limited to the individual.

Conditions of life and habit cause the many exposures

^{*} Discussion on paper of John Kent Sanders, A. M., M. D.

to be varied, because the nature of individuals is differently affected by the same exposures. Ill habits also affect different subjects to produce change of phenomena and a change in the cell structure as well as the influence upon the person. One person addicted to lacing may suffer from lung affection or heart weakness, while the menstrual function may be undisturbed. Another may be careless in climatic changes, in changes of season, or changes of temperature during a season, and suffer primarily with either lung, heart, stomach (digestion), kidney, or menstrual disturbance. Constipation or diarrhea may cause displacement, relaxation, or excitation of the organs associated with the life of puberty, or later with the menstrual organs, after being well established in their functions.

Stimulating diet or condiments may produce excitation which, unknown to the victim as such, yet induce sexual hyperæsthesia and extravagant loss of nervous vigor necessary to a healthy functional procedure of the organs involved. Excesses of starchy or saccharine dainties no doubt largely deplete the muscular system, add much to sexual difficulties early in life, and cause as well serious obstructions in the intestines, lymphatics, and chyle vessels. These effects slowly but no less surely weaken the uterus and associated structures and predispose to irregularities, and contribute to, if not directly cause, dysmenorrhea, without the aid of the effects of exposures and engorgements thereby produced (commonly called colds).

Sexual excitement may be induced by any or all of the above, which is intensified by abnormal abuse either directly, by manual aid, or by unconscious sexual hyperæmia and consequent ecstacy of dreams and other muscular and emotional attitudes or positions not known to the subject, and cause incomplete sexual satisfaction, just as certainly, and much more injuriously, than natural cohabitation abused; as injurious, but more dangerous, than self-abuse, because more subtle and more difficult to overcome. I am told by pathologists that the uterus contains no erectile tissue, consequently that organ does not partake in the

sexual ecstacy. If that theory is good and true by the science of pathology, it is not true by facts, which may be demonstrated by the experiment, as Galileo demonstrated the fact of the revolution of the earth.

As self-abuse of the male will produce stricture, so selfabuse, or chronic hyperæmia of the female genitalia and generative organs will induce cervical stricture, which is present in many of the cases of dysmenorrhea. The classifications of dysmenorrhea from ætiology and pathology seem to me to be very arbitrary for the reason of the very important part the sympathetic nerves take in all functional performances, especially noted at the orifices. We can readily comprehend how an apparent ovarian or fallopian source of dysmenorrhea may be dependent entirely upon uterine atresia, flexion, or specific inflammation of the endometrium, from subinvolution or any morbid sensitiveness of the uterus necessitating pain from the functional expulsion of the even normal menstrual fluids, just as we often have observed a severe headache, icterus dyspeptic or other phenomena to mask the error in the genitalia or menstrual system at the period of the monthlies or sexual ecstacies.

And so, also, have we observed the misleading pains of the uterus, when a patient will be able to state positively all the sensations of a painful consciousness of a womb, and be able to outline the exact position of that organ, and the organ itself when touched by the finger will convey to the mind of the subject the sensation sometimes reported "as if a boil existed upon the uterus." This class of cases is the most frequently mistreated and maltreated by the best "experienced gynecologist." The fact that many have been made tired of the reflexes by, to them, too frequent reminders, does not relieve the fact that for the proper recognition of these phenomena many are "forced to sea" in their pathology "without compass or rudder," hence the great misfortune to patient and the humility to physician if conscientious.

Therefore, for the above brief reasons, we should add to

the classifications given by Professor Sanders' paper and the authors generally the additional class of "reflexes" which exists so often either as complication, cause, or pathology, of which less is known than we are willing at all times to admit. To nervous reflexes are due many organic diseases that are never traced farther than the organ whose function we find imperfectly or painfully performed, and now more frequently slighted than the ills of the uterus and its appendages.

The cause which operates to change the influence of the reflexes from normal to disease-producing, in its effects upon the organs, produces within the range of the nerves involved something which augments the natural to excessive excitation, or deprives the organ of the activity and vitality to preserve healthy nutrition and retrograde processes required by all healthy physiological tissue or organs.

ELIAS C. PRICE, M. D.

I do not flatter myself that I can throw any more light on the treatment of dysmenorrhea than the average homeopathic practitioner. There is one thing that may be one of the great probable causes of the prevalence of the disease that Dr. Sanders had not mentioned; and one which I would not have dared to mention many years ago.

About thirty years ago, in conversation with an old homeopathic physician, he remarked that masturbation was a great deal more common among women than among men. I very promptly told him I did not think so. I do not remember his exact words, but his reply was something like this: "Perhaps you will find it out some day."

Several years afterward a lady who had been a former patient of mine in Baltimore, but who was then residing in a neighboring State, called to be treated for dysmenorrhea. While I was making an examination, she said, "I am afraid I have brought this trouble on myself." I said "How?" She said, "By gratifying myself." I immediately thought of my old friend's statement, and I concluded to ask some

questions. I said, "Do you think there are many girls that do that. She said, "About 99 out of 100; in fact, I do not know any that does not do it." I was perfectly astounded; even now, I cannot believe it is so universal as she represented it to be. May it not be more prevalent in certain rural districts, where girls from neighboring sections are in the habit of making prolonged visits to their friends in other sections of the country, and while sleeping together one may teach the other how to practice it?

A physician does not need to be told that this pernicious practice can become a very fruitful source of dysmenor-rhea.

SEPTIC FEVER.—A CASE FROM PRACTICE.

By Porter S. Kinne, M. D.

REALIZING with what care and anxiety the physician faces his cases of septic fever, and knowing how utterly useless in many cases are the usual modes of treatment, I feel it my duty to report the following case, which is but one of a number of which I am cognizant:

Mrs. M., aged twenty-eight years, slight build, primipara, was confined January 15, 1897. About two months prior to the confinement her lower extremities and pudendum became ædematous. I examined the urine carefully and at frequent intervals, and found it free from albumin or casts. I gave the case close study, and prescribed several remedies, but, in spite of all treatment the ædema increased, until, at the time of confinement, her legs and thighs were hard and swollen to such an extent that she could separate them but slightly, and the external parts, especially the labia majora, were enormously distended.

The outlook was not pleasing, and it appeared as if it would be impossible to deliver her at all; and at best I knew that laceration would follow. The labor was long and tedious, although the child lay in the first position. The patient was highly nervous, and after a safe time I decided it would be necessary to deliver with instruments.

Dr. Crooks was sent for, and, giving chloroform to full extent, I delivered her of a bouncing boy weighing twelve pounds. The result was as I feared: although the instruments were removed before the delivery of the head, the perineum was torn down to and around the rectum, without injury to the rectum itself.

Repair was made at once under thoroughly antiseptic precaution, and the patient left in a comfortable condition. She did nicely for three days, when the temperature rose; there was no pain or especial tenderness anywhere, no tympanites, and the parts looked healthy and were healing; lochia diminished, but normal in color and odor.

I at once ordered the professional nurse to give the vaginal douche every four hours. I gave the intra-uterine (creoline) douche every twelve hours. This was continued four days.

Internal remedies were: pyrogenium 30 every four hours, bryonia 3, and gelsemium 8 as intercurrents. With a temperature of 105°, and no signs of improvement, I decided to test the merits of Proto-Nuclein.

I discontinued the use of all other medicines, and gave the vaginal douche only (hot water). I ordered Proto-Nuclein, two tablets every three hours. After each vaginal douche (four hours) a Proto-Nuclein suppository was inserted well up in the vagina, the external parts were thoroughly cleansed with dioxide, and the Proto-Nuclein powder (special) was well dusted on the parts.

The improvement was marked. The temperature fell to 102° in twenty-four hours, and in three days' time had become normal. The patient made a most excellent recovery. In two cases of septic fever, occurring in the practice of other physicians, the same treatment was adopted after the fever had continued for three weeks, and the improvement was manifest within three days and continued until both patients made a most satisfactory recovery.

Proto-Nuclein not only surprised me and the various physicians by its wonderful and positive effects, but has resulted in the complete cure of these patients. After a personal knowledge of this kind, seeing is believing: I shall continue the use of Proto-Nuclein in my practice, and if the future yields as bright results as the past, I shall be highly pleased.

PUERPERAL MANIA.—A CASE.*

By W. M. FOLLET, M. D.

MRS. L., aged twenty-seven, blue eyes, brown hair, stout but flabby. Family history of insanity. First pregnancy passed through the gestative state without having a symptom. Delivered March 25, 1897. Labor normal and recovery prompt. April 18, 1897, patient's husband called at my office, and stated that his wife acted "queer" and had sleepless nights. On calling at the patient's home she at first refused to see me, but my excuse being to see the baby readily granted my request. Patient not inclined to be communicative. Whole personal appearance had changed; formerly very particular as to personal appearance, now just the opposite; sad, staring look; sat continually looking out of her window. This was all that could be learned at this visit. The following two days sufficed to develop the real picture of the disease. Full of anxiety as to the future of herself and baby; continually moaning, "Poor baby! Poor baby! What will become of him!" Does not want to see anyone. Weeps over her condition; "going to be a burden to her family." Wants to kill herself and baby. Sleepless at night—all symptoms < at night.

Lochia slighly tinged with blood.

Puls. was the first remedy prescribed, but on reviewing the symptoms carefully, the merest tyro could not doubt the remedy: one dose of the 200th cured in ten days.

^{*} Read before the Medico-Chirurgical Society of Central New York, December 2, 1807.

ELECTRO-THERAPEUTICS IN GYNECOLOGY.*

By E. G. FREYERMUTH, M. D.

OUR knowledge of medicine and surgery is in a state of continual transition, passing from good to better, and it may be truly said the medical literature, the practice of the art, and the surgical technique of to-day are the best in the history of the world. But who will say that we have attained perfection?

When Hahnemann founded the new school of medicine based on the law of "similars," he promulgated a doctrine upon which the medical profession became divided, a very large majority taking issue with the reformer in medicine. Yet that period marked a very important era in the history of medical science. One faction, by administering crude drugs to the well and noting their action, evolved a Homeopathic Materia Medica.

The other faction by slow degrees has decreased its former massive doses of compounds, containing sixty or more ingredients, to doses many of which resemble our "little pills," and whose formulæ comprise but three or four substances, and not a few but one.

If Hahnemann has not convinced all that "Similia similibus curantur" is the science of therapeutics, he has succeeded in revolutionizing the dosage and practice of the old school doctors.

In Hahnemann's day the profession did not know it all. Since then it has made marvelous advances, and yet we are very deficient.

As homeopaths our armamentarium gives us the advantage over our competitors. Yet we meet with many conditions that nonplus us and refuse to yield to our remedies. What remedy has in its pathogenesy retroversion or retroflexion of the uterus with the fundus bound down by adhesions? What drug has in its provings produced a myoma?—What simillimum is suggested to our minds when

^{*} Read before the Homeopathic Society of the State of Colorado.

we detect a stenosis of the os and an undeveloped uterus? We meet with these conditions almost daily, but our remedies only temporarily relieve the poor sufferers of a few of the concomitant symptoms.

I say it because I know it, that the homeopathic physician can surely and speedily cure such purely inflammatory and nervous affections of the female pelvic organs, as would require surgical interference by the physicians of other schools of medicine. But there are certain chronic inflammations with adhesive exudations and pathological states, such as those noted above, and others, that will stubbornly resist the action of our remedies, no matter how closely the drug pathogenesy may approach the totality of the symptoms presented.

Until recently the operating table held out the only hope of relief to such patients. Suffering womankind owes its gratitude to Apostoli, Erdmann, Goelet, and others, who have conclusively demonstrated that electricity will disperse chronic inflammations, destroy adhesions, absorb exudations, rectify displacements, arrest the growth of fibroid tumors, and restore to the pelvic organs their normal functions and tone.

Yet there are eminent physicians of all schools to-day who as stubbornly deny these claims and ridicule those who make them, as did the wiseacres in Hahnemann's time—and do even in our time—deny the claims of homeopathy and ridicule those who practiced it.

They have no clearer nor better conception of electrotherapeutics than has the street fakir, who with his formidable looking machine attracts the passer-by and sells him all the electricity he can "hold on to" at so much a trial.

Electricity intelligently applied is one of the most useful agents the surgeon and physician can command. See the astonishing manifestations of the Roentgen rays. It is not an optical delusion to observe the shadowgraph. Fully as remarkable effects are produced by it in diseased and abnormal tissues and conditions. It is not a "faith-cure," when we behold our patients restored to health under its influence.

The mistake of the profession is that it fails to thoroughly investigate this new therapeutical agent. Medical electricity may mean "franklinism," "faradism," or "galvanism." Faradism may be a current from the primary coil-coarse short wire-known as the current of quantity, or it may be a current from the secondary coil-fine long wire-called the current of tension, or it may be a current from the combined coils. Galvanism may mean electrolysis or galvanocautery. Electrolysis may be accomplished with either the positive or negative as the active pole. To use these electrical factors, each of which has a distinct and special action and influence indiscriminately is akin to prescribing for a patient by closing the eyes and haphazardly selecting his remedy from a stock of medicines, and cannot fail to give unsatisfactory results. Electro-therapy is but in its infancy; but it is a strong, vigorous, and growing infant, and in clarion tones of successful demonstration is appealing to the medical fraternity for attention.

That it is receiving attention is evidenced by the fact that prejudice against the electro-therapeutist is on the wane; by the consideration that so many practitioners are giving the subject; by the large circulation of the Journal of Electro-Therapeutics; by the increasing sales of high-grade medical batteries and appurtenances; and last, but not least, by the fact that so many of the leading medical colleges have lately included in their curriculum the study of electro-therapeutics.

The research and experimentations to-day with electricity as a remedial agent mark another important period in the history of medical science, and this infant, as it develops, will be as fruitful for good to suffering humanity as was—and still is—homeopathy. Will the profession again become divided? But I am not "hewing close to the line" of my subject.

The most marked and rapid advances in electro-therapeutics have been made in the treatment of the diseases of the female pelvis. Nothing else can compare with its usefulness in these affections. Its general use by gynecologists will make ovariotomy and kindred operations rarities. Like all powerful drugs it is a dangerous remedy in the hands of the ignorant, and like every remedy it has its place. It is by no means a panacea for all the ills woman has fallen heir to. Galvanism is contra-indicated in acute inflammations and after the development of pus.

Faradism—the secondary coil—will relieve the pain of the former, while it may cause rupture of the wall in the latter condition.

No sane physician who understands its action would for a moment entertain the thought of applying electricity to an ovarian cyst. In chronic salpingitis, ovaritis, cellulitis, and peritonitis galvanism is the remedy par excellence, and intelligently employed will not fail to gratify both physician and patient. The same may be said of nearly all forms of dysmenorrhea. I have yet to meet with my first failure in relieving the affections noted, and some of my cases have been pronounced incurable by reputable physicians.

The growth of fibroid tumors is arrested, and they are often made to diminish in size, and symptomatically cured, by electrolysis. This also has been demonstrated in my practice.

Uterine affections are no less responsive to this treatment. In chronic inflammations, hyperplasias, and displacements of the uterus either the galvanic or faradic current may be indicated, and both may have to be used to complete a cure.

My method of applying the electrical current to pelvic diseases can be explained by describing a few cases I have had under treatment during the past year.

CASE I. Mrs. F., aged thirty-five. For years has suffered extremely at every menstrual period. The pain was always worse the day preceding the flow, but continued more or less severe, during the entire period. Bilateral laceration of the cervix. Right ovary swollen and tender. Flow profuse. A noted homeopathic physician of St. Louis advised trachelorrhaphy, then, if no improvement was had, ovariotomy. Cervix repaired by a Chicago surgeon. No improvement at the expiration of a year. I gave her electrical treatments in the following manner: A Hayes

electrode, connected with the negative pole of a galvanic battery, was placed on the abdomen. A platinum electrode, connected with the positive pole, was introduced into the uterine cavity. A milliamperemeter and rheostat were placed in the circuit, and the current gradually turned on by means of the latter, until the patient felt she could stand no more. At first only 10 milliamperes could be borne, but at her last sitting 45 were taken with little discomfort. Two treatments a week were given for a month. The next menstrual discharge came in the nature of a surprise, her first admonition of its presence being the stain on her clothing. A feeling of malaise and a slight backache are all the inconvenience she now (at the end of nearly a year) experiences in connection with the menses.

CASE II. Mrs. S., aged thirty. Chronic salpingitis on right side. Menses painful and prolonged. Right ovary tender and tube swollen. Uterus immobile and lateroverted. Galvanic treatments every other day. Electrodes same as in Case I. Negative used as active pole, in uterus, except in the treatment before the flow was expected, when the positive was substituted. From 40 to 60 milliamperes were administered.

At the end of two months she was so much improved that she returned to her home in the mountains. The uterus was movable, in normal position; the ovary and tube free from tenderness; and very little pain during menstruation. The flow was not quite normal as to amount and duration, but she could remain no longer to complete the cure.

CASE III. Was a dispensary patient that made the rounds of the city dispensaries for relief from a backward displacement of the uterus. Came to my clinic with a pessary in situ, placed in position by the gynecologist of one of our numerous dispensary staffs. Owing to the pain it caused her she wished the thing taken away. Instructed student McGill to remove it, and the patient to return for examination and treatment at my next clinic, when she was examined by myself and class.

Diagnosis: Retroversion. Replaced the organ, introduced a bipolar electrode into its cavity, and applied the faradic current—primary coil—for fifteen minutes. When she came for the fourth treatment the fundus was in its normal place; but gave several more treatments. She was under observation for several months afterward, but no return of the displacement occurred.

This was a simple case, yet it proved to be an intractable one in the hands of those "specialists" who preceded me.

When displacements are complicated with adhesions, the electrolytic action of galvanism will first be required to destroy the bands that hold the uterus in its abnormal position. Faradism will then do the rest.

CASE IV. Mrs. T., aged forty-five. Was very much discouraged when she came to see me for treatment. Her "period" came too early and lasted too long. Was very weak and anæmic. Life was becoming a burden to her, yet she clung to it. Her former physician diagnosed her trouble retroflexion, but could do nothing for her relief. What he probably mistook for the fundus in the posterior cul-de-sac proved to be a retro-uterine fibroid tumor.

Treatment: Galvanism. Electrodes same as above. Positive pole in the uterus; 75 to 100 milliamperes. Two treatments a week for two months. Result: Menstruation normal. Has gained flesh. Is stronger and has good color. Feels like a new woman. Tumor still in place, but causes no inconvenience, and is not growing.

CASE V. Mrs. M., aged thirty. Ever since her first menstruation has suffered extremely at the "month." An examination revealed a "pin-hole os" and small, undeveloped uterus. Treatment: Galvanism, with negative as active pole. Prior to turning on the current my smallest electrode could not be passed into the uterine cavity, but 20 milliamperes soon permitted the instrument to enter to the fundus.

This treatment happened to be given a few days before the next flow. She passed through this "period" for the first time without pain. She is just getting over her second flow, and feels that she is cured. I will soon treat the uterus with faradism in order to develop it, and hope to soon be able to report that she has become a mother, "a consummation devoutly wished for" by her.

In my applications of galvanism, I allow the current to pass from three to ten minutes, giving less time to strong currents.

DIPHTHERIA.

By J. R. Young, M. D.

WHEN diphtheria first made its appearance in the world is hard to determine; and little would we care if it would take its departure, and that for good. It seems not to be partial to either climate, season, or locality, for it claims its victims on mountain, plain, and valley, in both warm and cold climates. It is always at home; in summer it is with us, and in the winter it goeth not away. In both city and country, sporadic cases always precede an epidemic, for a longer or shorter period. Generally at first only children are attacked, but afterward adults are seized; and there is no disease common to our country that is more dreaded, or that produces greater consternation in a neighborhood, than the report of the presence of genuine diphtheria.

There is a wide range in cases of diphtheria, both in the symptoms and in the virulence of the disease. One case may be mild and free from danger, while another is severe and almost certainly fatal from the start; but even in the mildest cases, there is such predisposition to rapid change that we can never feel that the patient is safe; for in a few hours all may be changed. New symptoms may arise, and the old increase to an alarming extent.

We recognize three distinct varieties, or rather stages, in this disease: the simple, the malignant, and the croupous or laryngeal. The difference between the simple and malignant is one of intensity, so that they may easily pass into each other, while in the laryngeal variety the false membrane extends down into the respiratory tract, instead of being on the fauces alone, causing the symptoms to be different in many respects.

Symptoms.—The premonitory symptoms, which precede by a day or two the actual onset of the disease, are a tired feeling, depression of spirits, great lassitude, pains in the back and limbs, loss of appetite, and sometimes nausea and vomiting, with slight chills, more or less fever, soreness of throat, with difficulty in swallowing. If the throat is now examined, we will find one or both tonsils red and swollen.

In from twenty-four to forty-eight hours, small yellow, or gray or ash-colored patches appear. In a few hours these spots spread and unite with each other, forming a dirty, ash-colored membrane that may spread over the entire surface of the mouth, causing so much soreness of the muscles of the mouth and throat that the patient cannot be induced to open his mouth to any extent. If this growth is now examined it will be found to contain many bacteria. Are they the producers of the disease, or does the disease produce them? Both theories have their exponents. But it matters little to us which is right, if we find the remedy that removes the disease and saves the life of the patient; and this brings us to the treatment.

The world is full of specifics, nostrums, and sure cures for this as well as all other maladies. The totality of the symptoms is the only guide for our treatment: each person should be treated according to his symptoms, and not by the name of the disease, nor is it necessary to destroy the bacteria which exist in the pseudo-membrane and tissues by poisoning or burning them. When the disease is cured they will disappear. The similar remedy given in the minimum dose will accomplish this.

In my own experience, I have received very little if any benefit from local applications, unless it be from hot water applications. Applying anything to the affected parts, from sulphur to caustics, does more good to the attendants, in satisfying their desire to have something done, than it

benefits the patient: in short, we deem it a constitutional disease, with local manifestations; and one that like any other disease, should be treated according to its symptoms. Neither shall I attempt to name all of the remedies mentioned in our books, that may be applicable to the disease, but will merely give some characteristics of a few that I have used in my own practice.

Apis mel.—Bright red color of the inflamed parts, with a puffy, varnished appearance. The first patches appear on the arches of the palate and uvula; the uvula is elongated and œdematous; cannot bear anything about the throat.

Lachesis.—Heat is very unpleasant to the patient; great anxiety and restlessness; very little thirst; the pains are of a darting, stinging nature; perspiration breaks out and dries up frequently.

Arsenicum alb.—Great fetor from the deposit, and oozing of blood from under the elevated portion of the membrane; sensation as of a hair in the throat; all the symptoms are worse at night; patient changes position often; drinks often, but little at a time.

Kali bichromatum.—The exudation extends into the throat and bronchial tubes, causing a croupy cough in paroxysms with expectoration of viscid, tough mucus, which may be drawn out in long strings; the tongue is red, raw, and shining; the deposit is of a greenish gray color; the tongue is covered with a thick, yellow coating; the pains shoot up into the ears, and down into the neck; deep-eating ulcers appear, and smell like decayed meat; there is a sensation as of a hair on the tongue (arsenicum, in the throat); aggravation of all of the symptoms after sleep (also lachesis). I think I have derived more benefit from this remedy than from any other.

Lachesis.—Begins at the left side, or spreads to the right; the throat is very sensitive to the touch, or to any external pressure; painful and difficult swallowing; sensation as of a foreign body in the throat; voice weak and hoarse; worse after sleeping, or from touching the neck or throat; great prostration and cardiac debility; peculiar, hard

aching all over, so that the patient wants to change position often.

Lycopodium.—Begins on the right side, or is worse on that side; much swelling and pains in the throat, with spasms in swallowing; cannot drink without choking; where the parts are not covered with the deposit they are brown in color; a feeling of constriction in the nose, throat, and chest, worse on the right side; aggravation of all the symptoms every day from 4 to 8 P. M., also after sleeping; difficult urination, as it will not readily start; red sand in the urine; great rumbling in the bowels.

Mercurius cor.—The exudation spreads very rapidly and extends into the nose, from which a profuse excoriating discharge flows; a rapid destruction of the parts; it seems to eat them away, and yet there is less prostration of the patient than we would naturally expect to find.

Rhus tox.—Bloody saliva runs out of the mouth during sleep; sticking or stinging pain in the tonsils; the tonsils are covered with a yellow exudation, especially the right one; worse when beginning to swallow, but after a little effort can swallow better; there is a general typhoid condition, with thirst; the parotid glands are a good deals swollen; patient is restless, wakes up often, and complains of pains in the throat; a transparent, jelly-like discharge from the bowels.

TYING AND DRESSING THE UMBILICAL CORD.*

By Dr. A. Schwab.

A FTER the child is born it remains still attached to the mother by the umbilical cord. The first care of the accoucheur or of the midwife, therefore, consists in completely separating the infant from the mother by a section of the cord.

This operation, so simple in appearance, has nevertheless given rise to innumerable discussions among accou-

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cheurs, upon the following points: Is it advisable to tie the cord before cutting it? At what time should it be tied, and what substance should be employed for the ligature? What should be the dressing of the cord, after cutting?

We will consider these different points in succession.

I. And, first of all, is it necessary to tie the cord?

Some accoucheurs, basing their opinions upon what takes place with animals, have denied the usefulness of tying the cord before dividing it. And these authors—P. Dubois, Depaul, Zimmermann, Wolfart, and others—have made a great many times simple section of the cord without tying, and have not observed any consequent hemorrhage. But we must add that in all these cases the respiration of the infant was thoroughly well established.

In effect, when the respiration is regularly carried on, the blood from the right heart flows through the lungs, preventing thus the reflux toward the umbilical vein; and, on the other hand, the rapid retraction of the umbilical arteries opposes a hemorrhage from these arteries (Tarnier, Ribemont). But the respiration may be constrained and imperfect (from tightness of the clothing, obstruction of the respiratory passages by the amniotic liquid, congenital feebleness, etc.), and the circulation, continuing in the cord, may give rise to grave, often fatal, hemorrhage, if ligature of the cord has not been practiced.

Besides, the argument drawn from the conduct of animals does not stand investigation; animals bite, crush, or tear the cord to divide it, a very different thing from the clean incision of a cutting instrument. En résumé, all physicians are in accord in recommending the ligature of the cord, or more exactly of the fetal end of the cord in all indistinct cases.

2. The necessity of ligating the cord being recognized, when should it be done? Upon this point accoucheurs are of different opinions. Mauriceau, Clément, Zurisel, recommended the ligating of the cord after delivering only; that is to say, after the expulsion of the placenta. M. Auvard calls this the retarded ligature. This method has been entirely abandoned to-day.

At the present time two methods are in use—immediate ligature, practiced immediately after the birth of the child, and delayed ligature, made some minutes after expulsion.

Cazeaux, Verrier, Joulin, Penard, and others recommend tying and cutting the cord immediately after the birth of the infant. Stolz, advocate also of the immediate ligation of the cord, says, nevertheless, to wait until the infant breathes freely and cries before tying the cord.

On the contrary, Nagele, Leroy, Jacquemier wait until the pulsation of the cord becomes very feeble.

More recently, under the impulsion of Professor Tarnier, this question has been revived, the authors basing their conclusions upon purely scientific grounds. M. Tarnier thinks that the ligature made immediately after the expulsion of the infant deprives the child of the amount of blood contained in the placenta which really belongs to the infant.

Professor Tarnier, through his pupil, M. Budin, had a series of experiments made, intended to estimate the amount of blood which flows from the placental end of the cord when the immediate ligature is practiced, and the amount which runs out when the ligature is made from one to two minutes after the cessation of pulsation in the umbilical artery.

In a word, M. Budin estimated the quantity of fetal blood contained in the placenta after the birth of the child, and of which it is deprived by the immediate ligature. This constitutes the reserve blood of M. Schucking.

M. Ribemont in 1879 repeated these experiments. From the different experiments made it appears that the delayed ligation of the cord, that is, after pulsation had ceased, gave the infant the benefit of a quantity of blood estimated at 92 grams (3 ounces). If we accept the opinion of M. Weckler that the total amount of blood of a newborn child of 3000 grams (6 pounds) is 158 grams (5 ounces), it may be readily seen that the child is subjected to the deprivation of a considerable amount of blood by the immediate tying of the cord.

M. Ribemont, in addition, has demonstrated that the blood contained in the placental vessels is necessary to the normal establishment of the third circulation. Helot of Rouen demonstrated that delayed ligation of the cord notably increased the globular richness of the blood of the newborn.

Finally, MM. Budin and Ribemont have proven by their experience that the initial diminution in the weight of newborn children is less marked after delayed ligation than after the immediate ligature, and at the tenth day the increase of weight of the infant was much more considerable after delayed ligation. At the present time most accoucheurs practice delayed ligation. But when is the best time to make the delayed ligation?

M. Porak (theses of Paris, 1878) agrees with Schucking that the penetration of the placental blood in the body of the fetus is due to the retraction and the contraction of the uterus, regarding the umbilical arteries as the safety valve of the fetal circulation. He believes, therefore, that the umbilical cord should be tied when the umbilical arteries have ceased to pulsate. If, according to M. Porak, on the contrary, one delays ligating the cord for several minutes after the cessation of the pulsations of the arteries. one risks overcharging the circulatory system of the infant, thus predisposing it to hemorrhages and to icterus. MM. Budin and Ribemont have clearly demonstrated that the blood of the placenta passes into the fetus through the thoracic inspiration of the child, and recently, M. Maygner (1896) has shown the exclusive rôle played by thoracic respiration, demonstrating by eight observations that the cord continues to pulsate and the blood continues to pass from the placenta to the infant, even when the placenta had been delivered at the same time as the infant.

In a word, the opinion of M. Porak does not find any defenders, and the ligation of the cord is made in the following manner: When the infant is born, it is laid transversely between the limbs of the mother, to whom it remains attached by the cord; the mouth and throat are cleared of

mucus; it is superficially wiped over the whole body with a dry linen cloth; and is then wrapped in warmed linen.

We may then wait until the feto-placental circulation has entirely ceased, and the cord no longer pulsates. But it is necessary to exercise care with regard to the existence or non-existence of the funicular pulsations, and examine the cord sufficiently far from the umbilical attachment, for, in the neighborhood of the umbilicus, the pulsations may be felt for a long time after the feto-placental circulation has stopped. The pulsations in the cord last in general for some minutes. When the pulsations have entirely ceased the cord may be tied.

In general, it is sufficient to place a ligature upon the fetal end of the cord. Some accoucheurs, nevertheless, put on two ligatures, cutting the cord between them. But a ligature upon the placental cord is useful only in case of twin pregnancy, when there is a common circulation between the two fetuses. M. Auvard makes a ligature upon the placental end, "in the depth of the vulva to have an index of the separation and descent of the annexes."

3. Where and how should the cord be tied?

It is necessary to place the ligature two or three fingerwidths from the umbilicus. If the first ligature gives way, there is then sufficient room to make a second ligature. It is also well to put the ligature at a sufficient distance from the umbilicus to avoid the danger of including a loop of intestine, in the case of umbilical hernia.

The cord having been ligated, it is cut a centimeter beyond the ligature; care being taken, before dressing the infant, that there is no hemorrhage from the cord. To make the ligature, a strong waxed thread or cord of twisted silk may be used. But it is necessary to use a ligature which has been made thoroughly antiseptic by boiling, or immersion in a bichloride solution. The section of the cord should be made with scissors which have been rendered thoroughly antiseptic by dipping in a phenic-acid solution.

If these antiseptic precautions are omitted, it is at the risk of seeing infectious accidents follow (peri-umbilical ery-

sipelas, lymphangitis, omphalitis, asteritis, phlebitis, septicæmia).

Therefore, with a strong thread, made antiseptic, a first ligature is made and for greater security is tied with a surgeon's knot. The knot should be tightly and sufficiently drawn to close the vessels, but it should not be drawn so tight as to cut the cord; then the ends of the thread are passed around the cord in the groove made by the thread and tied in a second knot directly opposite the first.

But there are cases where the ligature such as we have described does not give sufficient security. We refer to such cases as where the gelatin of Wharton is very abundant, or in other words the cord is gras. What takes place with these cords? The gelatin of Wharton rapidly dries, the umbilical vessels are no longer compressed by the ligatures, and grave hemorrhages may follow; particularly if the infant strains or is constipated.

Various methods have been recommended for the prevention of hemorrhages in these cases; one accoucheur recommending the super-imposition of two or three ligatures, but these three ligatures become simultaneously inefficient. Another, the placing of a button upon the cord to press out some of the jelly of Wharton, and then ligation. M. Tarnier first, and, later M. Budin, recommend an elastic ligature. M. Budin uses an elastic ligature of two millimeters of Charrière thread. "The thread is drawn with a moderate tension about the cord, which it enwraps a number of times, and tied with a double knot."

But the elastic thread may slip and become loose. To prevent this M. Tarnier devised the method of the match. He applies on the cord, and parallel to its length, a small piece of wood like a match. The cord and the wood are then bound together with the elastic ligature, the wood preventing the thread from slipping. When the ligature is tied the ends of the piece of wood are taken between the fingers and broken in the center by pressure from the other hand; the broken pieces are withdrawn and the elastic ligature holds strongly. This elastic ligature exercises a

strong and continuous pressure without danger of cutting the cord.

But one has not always an elastic thread at hand, and M. Budin has devised the following method, which he describes in L'Obstétrique (January, 1896). "a. With a linen thread, single or double, about twenty-five to thirty centimeters long and which has been immersed in a bichloride solution, a circular ligature, very tight, is made about the cord two or three centimeters from the umbilicus. The cord is then cut one centimeter beyond the ligature. b. The cut end of the cord is turned upward; the two ends of the ligature are separated, one being carried in the groove made by the ligature around the cord to the opposite side; the two ends are brought together upon the cut surface, crossed, drawn tightly, and tied. This second perpendicular ligament separates the vessels of the cord. c. It is sufficient then to ligate each one of these divisions of the cord, the two ends of the thread passing to the right and to the left of one of these divisions; they are crossed, drawn tightly, and tied." This method has always given M. Budin excellent results.

If it happens, in the course of the ligature of the cord, that it is cut too close to the umbilicus, an attempt may be made to take up the vessels with forceps and ligate them with silk.

4. Dressing the Cord. Formerly, after the cord was ligated, it was dressed with a piece of linen cloth covered with cerate of vaseline. To-day, these dressings, which prevented the drying of the cord, are no longer used, and only the most simple dressings are employed. A small wad of absorbent cotton, antiseptic and dry, is applied to the stump, and renewed as often as necessary, being held in place by a bandage or simply by the clothing. But, with this dressing, it is necessary to be careful to turn the end of the cord upward to avoid its being contaminated with the urine or fæces.

Lately some authors—Keilmann, Wainstein, Bouffée de Saint-Blaise—advise against bathing of the infant, at least until the cicatrization of the umbilicus is complete. Bathing constitutes, in effect, for the umbilical stump a traumatism, and appears to retard its desiccation, and, in addition, the water of the bath favors the infection of the umbilical wound. In the clinic of Keilmann at Breslau, none of the four hundred infants who were not bathed had the fever; and more, these children lost less in weight than those who were bathed, and the increase of weight began with them a day sooner and was more regular. The falling off of the cord took place on the seventh or eighth day, and he never observed any umbilical complication. From which M. Keilmann concludes that the abandoning of the bath is beneficial to the infant.

The cord having fallen off, the umbilical cicatrix is usually perfect and any further treatment unnecessary. If a small inflamed suppurating surface remains, it is sufficient to apply a dry antiseptic dressing.

TWO CASES OF UTERINE MYOMA AND SOME LESSONS THEY SUGGEST.*

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AND

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THE natural history of disease for its own sake will always secure for itself patient and scientific students, but the therapeutist will seek to know what is known and knowable of its course for the practical benefit of his patient. As the young medical student must be familiar with the normal or physiological state of health before he is capable of judging of the importance of departures therefrom, so must the student of disease ascertain, as far as possible, the usual or natural course of an illness before

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he is competent to form an opinion as to the effects of treatment or to advance an accurate prognosis.

Even the worst enemy of homeopathy will acknowledge that by its alleged do-nothing methods the eyes of the profession have been opened to the value of the vis medicatrix naturæ. For "active treatment," e. g., of pneumonia, resulting in a mortality of from 20 to 30 per cent., the masterly inactivity of "expectancy" has, through the influence of homeopathy, been substituted, with an improvement in the death rate of 10 to 20 per cent. Homeopathic practitioners, then, have been instrumental in throwing a flood of light on the natural history of disease, even though it may have been unintentionally, for if they did not leave their cases to nature, they emboldened others to do so.

From the knowledge thus obtained the medical man is able to say that a disease like pneumonia will probably run a certain course, and will reach its crisis on one of a limited series of days, and, in all probability, in a healthy subject at neither extreme of life, result in easy recovery. He is able to point out and guard against the danger of collapse at the time of the critical drop of the temperature. Again, he knows the danger of nephritis in scarlet fever, and, especially during the desquamative stage, can warn the patient of his danger and adopt preventive measures. If in such cases he omits precautionary measures he does not act up to the light which he either possesses or ought to possess, and he incurs and is worthy of blame.

In other words, the doctor (as the term implies) must be a teacher. His knowledge enables him to foretell, to prophesy, not indeed by an inspired revelation but by a process of calculation based on an accumulation of fact, his own and that of others. He is bound to place such knowledge and before-sight at the disposal of his patient to indicate to him (or his representative) the probable or certain course and issues of his malady, and to guide him to the best way of escape if a way exist.

The steady but rapid increase of human knowledge is so great that even a Macaulay's schoolboy could hardly keep

pace with it. With this goes the fact of the gradual extinction of the "good-all-round man." In few instances is the presence and advice of such a person more needed than in the class of cases which forms the subject of this paper. When the combined wisdom of physician and surgeon cannot be secured in one person, it is essential that the two should meet and form a united judgment on the medical and surgical aspects of the case, based on knowledge obtained from the bedside, the natural history of similar cases, the operating table, and the post-mortem room.

Let us see if these remarks—somewhat of the nature of truisms—have any bearing on, or receive exemplification by, two cases which have recently been under treatment in the London Homeopathic Hospital.

On September 3, 1897, Mary S., a short, squarely built, single woman of dark complexion, æt. forty-one, came to the out-patient department; she could walk on the level, but could not get upstairs by herself, and could not lie down on the examining couch. She was at once admitted to the wards. The patient's own history is important in three particulars. Three years ago she had amenorrhæa for five months, after which the period was regular and somewhat excessive, but menstruation ceased in August, 1896, i. e., when the patient was forty years of age. Twelve years ago the patient had an operation for uterine polypus. There was no history of acute illness except "quinsy" twice.

On examination the abdomen was found to be enormously distended, measuring fifty inches in circumference. The greater part of it was dull, with a resonant area across the abdomen in the line of the transverse colon. There was free fluid in the abdominal cavity, but in spite of the fluid and tension solid masses could be felt, especially in the right iliac region. Vaginally the uterus was found to be drawn up, and there were some solid growths felt at the vault. No accurate conclusion was possible, but a solid, and probably myomatous, uterine tumor was diagnosed.

The legs and face and skin of abdomen were ædematous, and had been so for some two or three months. On the skin of the abdominal wall there were a number of bullæ, from some of which serous fluid was oozing. The heart sounds were feeble and the mitral systolic was roughened. The apex beat was not located, but the heart seemed to be pushed up.

To relieve the pressure gradually a Southey's tube was inserted into the abdomen, and one hundred and forty-four ounces of serous fluid were drawn off. The quantity of urine was very small, not exceeding twelve ounces in twenty-four hours, but there was no albumin or sugar; specific gravity 1020; copious urates. Apocynum and arsenic were first administered; and after two days they were replaced by strophanthus. The patient had been getting about a little until she came into the hospital, but she rapidly got worse, anasarca increased; she had an attack of faintness with some convulsive movements and unconsciousness on the 5th of June, from which she rallied quickly. The next afternoon she became very blue, pulseless and convulsed, and died in a few minutes, in spite of ether and strychnine hypodermic injections and artificial respiration.

At the post-mortem examination a large multi-nodular cystic myoma was found, filling the abdomen and pushing up the diaphragm. Across the upper part, the transverse colon was closely adherent, and the enlarged left fallopian tube stretched across a nodule to the left and low down. There were a number of large cysts and many small ones; some of the nodules were solid fibroids—the majority were myomata, soft or cystic. Adhesions were very numerous, and it would have been quite impossible to remove the tumor by operation. After letting out the fluid of the cysts the solid matter weighed over twenty-seven pounds.

The next patient * was Mrs. F., æt. forty-three, but looking older, gray since twenty-eight, married seventeen years and never pregnant. She was anæmic, but not extremely so, and dyspnæa on exertion was present, and had been

[#] From notes taken by Mr. P. Higgens, House Surgeon.

noticed two or three months. Patient has had no rheumatic or scarlet fever, typhoid or diphtheria.

Menstrual life had been fairly normal, with the exception of, on one occasion twelve months ago, "a severe flooding." The periods lasted seven days, and latterly have been excessive and occurring every three weeks.

She was admitted on November 27; the last period occurred on November 5, and it had not recurred on the 29th.

Patient stated that she had noticed enlargement of the abdomen three months or more; twelve months previously she believes her "stomach was quite flat."*

On examination a large, rounded central abdominal tumor was seen: it extended well above the umbilicus. It was smaller at its lower part, and the bladder was drawn up in front above the pubes, and when distended could be seen extending two-thirds of the distance to the umbilicus. The tumor was globular, smooth, and elastic. It felt like a tense ovarian cyst, but no definite thrill was obtainable; if cystic the walls were very thick. Vaginal examination threw much light on the condition, and revealed the following interesting and important facts: extending well into the pelvis, and to within about 1 1/2 in. of the vaginal orifice was a hard, nodular, non-sensitive mass. This tumor nearly filled the pelvis, was most prominent on the left side, and pushed the uterus over to the right. This organ lay close to the right pelvic wall, and was high up, almost out of reach. The hard mass described could, when the bladder was empty, be felt bimanually lying below the globular abdominal tumor above mentioned. But pressure with the external hand, both upon the abdominal and the pelvic tumors, was readily communicated to the finger in the vagina, whether resting on the tumor or on the cervix uteri. When the abdominal tumor was drawn up by an assistant the cervix was raised

^{*}She had been under Dr. Ord's observation for a few weeks, who on perceiving the increase in the size of the growth, sent her up from Bournemouth for operation.

from the finger, and when released it re-descended heavily upon it. The evidence, therefore, of the close connection of the tumors with the uterus and with one another was tolerably complete.

The interpretation of the phenomena was plain and striking. The pelvis was occupied by a hard fibroma of long standing, growing from the left side of the uterus and pushing it over to the right. This tumor probably burrowed into the left broad ligament. From near the fundus of the uterus sprang another tumor, recent, soft (possibly even cystic), rapidly enlarging, and dragging up the bladder—a myoma very elastic, if not actually containing fluid.

The urine averaged about forty ounces daily, specific gravity 1020; phosphates were present but no albumin.

The cardiac condition is described on a subsequent page. At a consultation of the staff operation was decided upon. The usual preparation by rest in bed, light but liberal diet, and thoroughly emptying the bowels, was carried out. On the morning of December 2 the patient was anæsthetized by Mr. Lestock Reid; ether was given, and the patient was admirably managed by the administrator; no rigidity, straining, retching, or contretemps of any kind occurring throughout. Mr. Johnstone gave his valued help at the operation. A long incision was made extending 11/2 inch above the umbilicus. The abdominal tumor was found to be so elastic as to lead to the exclamation that there was "no doubt of its being cystic now"; it was easily got outside. The intestines were carefully protected, and there being no tension they did not attempt to protrude. The broad ligaments were tied off outside the ovaries (which were very large), and as this was done the pelvic mass was gradually raised from its hollow. After ascertaining the exact height of the bladder wall a transverse incision across the front of the tumor from one broad ligament to the other was made, about one inch above the aforenamed viscus. The peritoneum was divided by this cut, and was stripped downward together with the bladder. After a similar incision had been made behind.

the uterine arteries could be felt pulsating and they were ligatured. By this time the hard pelvic fibroid was thoroughly raised from its bed, and only a small pedicle formed by the cervix had to be dealt with. As a precaution this was ligatured by transfixion and the cervix divided. The plug of mucus in the cervical canal was not disturbed, but the canal was closed by fine sutures, and the stump was allowed to drop to the floor of the pelvis. The anterior and posterior edges of peritoneum were approximated and united by fine continuous sutures over the pedicle, leaving it retro-peritoneal. Except the stump of the broad ligament, no raw surface was left in the pelvis. A drainage tube was used.

During the operation it was noticed that the veins of the remnant of the left broad ligament had become very much distended.

The operation was followed by very little shock, the patient rallying well and passing urine naturally by the second day. After a few hours a most troublesome cough set in, which caused great abdominal pain. Vomiting ceased after twenty-four hours; there was no distention at any time, and the urine did not contain albumin after the operation. The Keith's glass tube was left in two days, and a rubber one replaced it for twenty-four hours; after that no further dressing was required.

The bronchial cough, with purulent expectoration, gave great distress and was difficult to relieve.

The heart sounds were as before the operation until about the 6th, when the loudest bruit was heard midway between the aorta and the apex.

On the 9th, in the same situation, the bruit was noticed to be distinctly musical in character, but this high pitch was confined to a very small area. Cough improving, but the patient was weak and pale.

On the 10th patient was allowed to be propped up in bed by a bed-rest. The next morning she complained rather suddenly of pain in the left leg, especially the calf, and thrombosis of the femoral and saphena veins was discovered. On the 13th the area of the musical bruit had extended, and it was thought to be exocardial; the leg was doing well. After this the patient continued to convalesce, the musical bruit gradually disappearing and the swelling of the leg going down. She was kept very quiet in bed for some weeks, was lifted out on the 10th of January, 1898, and left the hospital quite well.

Here are two cases sufficiently alike to admit of fair and advantageous comparison. Any difference in the two was in the first patient's favor, both as regards age and strength. Her case furnishes such an example as is not easy to obtain of the natural history of disease, practically undisturbed by Twelve years before, a polypus was removed from the uterus, and this furnishes us with a probable date as to the duration of her tumor. At what period it became cystic we have no evidence, except that it grew much more rapidly during the last year. It proved its innocence by leaving her fairly well and strong till within a few months of her death. It proved its noxiousness (though technically not malignant) by killing the patient in a simple mechanical manner. Pressure on heart, kidneys, and other viscera induced cardiac weakness and dilatation, renal inadequacy and anuria, uræmia, orthopnœa, convulsions, and death. Operation fortunately was not to be thought of when she came under medical observation, and at the autopsy the numerous adhesions showed that the growth had probably long been inoperable.

The clear inference in this case is that the patient required some wise physician gifted with foresight to warn her of the future, and a surgeon to advise her as to the possibility of the safe removal of the tumor. The patient waited until urgent symptoms developed because she was ignorant and unadvised.

The second patient was seen by Dr. Ord, who gave her the benefit of the prophetic power possessed by the educated and judicious physician. He saw that the prospects of the patient if left to nature were practically those of the first-named case, and those who knew both patients could

see that her chances were even less favorable. Case II. was diagnosed to be one of soft and possibly cystic myoma of the uterus. The evidence went to show that it was growing. It is a point to be borne in mind, and which we wish to emphasize both from the medical and surgical side, that such a condition demands prompt surgical interference. To wait until symptoms arise is to wait until the growth has made itself obnoxious through enlargement, through peritoneal irritation and adhesions, or through damage to the uterine appendages. In these and other ways the magnitude and danger of an operation are increased, and the patient's chances are lessened through local causes. The same undesirable end may be attained through diminution of the patient's general resisting power. Anæmia will tend to increase; through malnutrition the heart muscle will fail and dilatation be induced. Or the mere added work thrown on the heart by a massive tumor will cause hypertrophy, to be followed later by failure of power. For local or general reasons—or both—procrastination of operation means a courting of disaster.

As has been pointed out in the London Homeopathic Hospital reports, increased tension at the radial pulse often accompanies uterine myomata. The bearing of this on the question of operation is real and direct. The significance of such increased tension arises from the secondary changes brought about by it in the heart and vascular system. After tension has existed for some time, hypertrophy of the musclar coats of the arteries is sure to follow, as well as of the wall of the heart, and later on degenerative changes which lead to a failure of the circulation.

In cases where there is marked anæmia low tension may be present, and with it a weakening of the myocardium with consequent dilatation of the heart and failure of the mitral and tricuspid valves. The danger of this failure is very much increased by the presence of a large tumor in the abdomen, and the interference which it gives rise to in the general circulation.

The first case was seen in the final stage, when after a

long gradual failure death took place in consequence of enfeebled circulation. The second case was fast approaching the same condition.

At the consultation one of the chief points in deciding for or against operation was the state of the heart. There was a loud systolic murmur heard best in the pulmonary area, but it could also be heard at the apex, and it was a disputed point whether there was mitral incompetence. After the operation the weakness and troublesome cough led to further dilatation of the heart, and the musical murmur was probably due to incompetence of the tricuspid valve, though at the time it was thought that it might be exocardial.

On page 156 we have implied that to treat these cases by radical surgical methods or to leave them to nature are the only practical alternatives. There is no question here as to the use of palliative medicinal means, for there is no clinical evidence of drugs having any influence on soft myomata. Nor would one expect much influence. A tumor of the uterus arising before the menopause and unaffected for good by its onset, whether natural or artificial, is not likely to be benefited by drugs—ordinarily much less potent uterine agents than the menopause.

Though the cases here adduced do not show this fact, it is, nevertheless, well recognized that soft and cystic myomata are not diminished by the cessation of menstruation either natural or resulting from the removal of the uterine appendages.

SUMMARY.

- I. These observations refer primarily and chiefly to soft or cystic myomata, which require complete mental differentiation from hard fibroids.
- 2. The natural history of the former differs from that of the latter in being uniformly bad.
- 3. The effect on the heart may be summarized as follows:

In addition to the actual interference with the circulation caused by the pressure of a large tumor, failure of the heart

may result from long-continued increased tension or from low tension; the latter occurs more especially when there is marked anæmia.

- 4. Soft and cystic myomata are uninfluenced by the menopause; it is in vain to defer treatment on account of its proximity.
- 5. Fibroids must be treated on their merits; soft and cystic myomata have no merits, and must be summarily dealt with as soon as diagnosed. They require total removal, quite apart from the presence or absence of symptoms. The better the patient's health the better her chance of recovery.
- 6. There is no clinical evidence that these tumors are influenced by medicines.
- 7. Hemorrhage is less severe in myomata (soft) than in fibroids (hard).
- 8. The two kinds of tumor may coexist in one patient, as in both these cases.
- 9. It is desirable, on account of the different clinical course of hard and soft "fibroids," that different names be used for the two varieties. The hard variety might conveniently retain the name of fibroma, and the soft that of myoma.



Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

SAW PALMETTO. Its History, Botany, Chemistry, Pharmacolgy, Provings, Clinical Experience, and Therapeutic Applications. By Edwin M. Hale, M. D. Philadelphia: Boericke & Tafel: 1898. Cloth, 50c.

The exhaustive treatise of Dr. Hale upon sabal serrulata is a valuable contribution to the study of the therapeutic value of this drug and will largely extend the sphere of its usefulness. Heretofore the use of the saw palmetto has been principally confined to the treatment of genito-urinary disorders, but we learn from this book that this is but a very small part of its therapeutic value. It has also been successfully used in the treatment of iritis where the prostate gland is involved, in chronic inflammation of the middle ear, as a spray in laryngitis, bronchitis, and other throat disorders, chronic incontinence of urine, chronic and acute gonorrhea, urinary fistula, enlarged prostate and prostatic troubles, loss of sexual power in men, as well as other diseased conditions. It should also be adapted, from the provings given, to the treatment of uterine disease, metritis, pelvic cellulitis, ovaritis, salpingitis, and similar disorders. One of the symptoms obtained from a proving, and which should prove a keynote to the remedy, if confirmed, is the desire to be let alone: "I feel like I would like to go away and die alone—like some suffering animal"; but in a thoroughly scientific, up-to-date materia medica we presume such a symptom would be expurgated. The book is certainly worth very much more than its price to any physician.

A MODERN PATHOLOGICAL AND THERAPEUTICAL STUDY OF RHEUMATISM, GOUT, RHEUMATOID ARTHRITIS, AND ALLIED AFFECTIONS. By EDMUND L. GROS, M. D. Translated from the French.

This is an interesting monograph, from E. Fougera & Co., giving the ancient and modern views of the rheumatic affections, with former and present methods of treatment, including that with colchi-sal or colchi-nine and salicylic acid. FLINT'S ENCYCLOPEDIA OF MEDICINE AND SURGERY. By various writers, arranged upon a new system which embodies the methods of treatment employed by eminent practitioners of Medicine. Second Revised Edition. New York: J. B. FLINT & Co.: 1898. One Volume, 1600 pp. \$5.00.

As now appearing in a second revised edition, brought up to or down to-as the reader may prefer-date, Flint's Encyclopedia is the best and most comprehensive work of the character that we know of, for not only are the more common subjects of medicine and surgery fully and clearly treated, but obstetrics and gynecology are exhaustively treated and in accordance with the present state of these sciences and arts. We notice also in glancing over the work that a number of new titles and subjects have been added to the already copious list. Thus we find: Ambulant Treatment of Fractures; The Gibney Method of Treatment of Sprained Ankle; Bicycling; Anti-toxin Treatment of Diphtheria; The Dosimetric Method; Vacuum Treatment; Hot Air Treatment; Bubonic Plague; and numerous other additions. Though somewhat bulky, it is a book which will always be within convenient reach, as the systematic arrangement of the headings facilitating quick reference, invites to constant use, as well as the fact that the necessity of referring to a number of volumes to find a needed bit of information is done away with by the very complete and comprehensive character of the encyclopedia.

THE TREATMENT OF DISEASE BY ELECTRIC CURRENTS. By S. H. MONELL, M. D., Author of Manual of Static Electricity, Founder of the Post-Graduate School of Clinical Electro-Therapeutics and Roentgen Photography; Fellow of the New York Academy of Medicine. 1100 pages; size, octavo; extra cloth, gilt. Price \$8.00. New York: William Beverly Harison, 3 and 5 West Eighteenth Street.

As the author well says in his preface: "Galvanic, faradic, and static currents are important medical remedies which can only be prescribed by those who know how to use them," and the treatment of disease by the various electric currents has become so essential a part of the practice of medicine that it must be studied and applied as any other therapeutic agent. As this work is intended as a working handbook for the general practitioner it has been written so as to be readily understood and clearly comprehended, in the clear and convincing style of Dr. Monell, which is readily followed, not only without fatigue, but

with growing interest. The central facts of electro-physics and physiology have been condensed into a few chapters, the greater part of the work being devoted to the therapeutic applications of the electric currents. The book is eminently practical detailed directions being given for the selection of the current best adapted to each particular case and purpose, the choice of poles, application of electrodes, regulation of the dose, and duration and frequency of treatment, so that the physician can find all the information necessary to the treatment of his cases. Every essential scientific fact is clearly given, in which respect no other work upon electro-therapeutics can compare with this. Chapters I. to XIV. constitute a very complete treatise upon electric currents, their production, and their physiological and therapeutic actions, and will repay study, even though one does not use them therapeutically. The remaining chapters, XV. to LXX., are devoted to practical theapeutics, each chapter forming as it were a clinic in itself upon the various diseased conditions. The book is well printed and bound, fully illustrated, and will be cordially welcomed by all who are interested in electro-therapeutics as the best and most complete work upon the subject published.

ORTHOPEDIC SURGERY. By JAMES E. MOORE, M. D., Professor of Orthopedia and of Clinical Surgery in the College of Medicine of the University of Minnesota. 177 Illustrations. 354 pp. 8vo. Cloth, \$2.50. Philadelphia: W. B. Saunders: 1898.

Orthopedic surgery, in common with general surgery, has made rapid advance within the past few years. How great the advance has been can be understood only by a comparison of the present work with former treatises upon the subject, which have usually appeared as appendixes to some other work. It has been the aim of the author in writing this book to eliminate everything that was not of practical value and to produce a moderate sized volume which would prove a helpful reference book for the general practitioner. Special stress is laid upon early diagnosis and only such methods of treatment are given as, in the experience of the author, have yielded the best results. The book is conservatively written from the middle ground between the surgeon who operates too frequently and the orthopedist who seldom operates.

THE RUBAIYAT OF DOC SIFERS. By JAMES WHITCOMB RILEY. New York: The Century Co.: 1898.

The hero of this pleasant little story is the typical American country doctor of a bygone day, the doctor who was loved by all for his simplicity and kindness of heart, but who like the dodo is now extinct. In these days of scientific progress and microbian omnipresence, Doc Sifers would find himself a very ancient backnumber. The book is beautifully printed and illustrated, and will be read with much pleasure by physicians as well as laymen everywhere.

HUGH WYNNE, FREE QUAKER, Sometime Brevet Lieutenant-Colonel on the Staff of His Excellency General Washington. By Dr. S. Weir Mitchell. Two vols., 16mo., pp. 306-260. New York: The Century Co., \$2.00.

The story of Hugh Wynne, the son of the sturdy Free Quaker, who through the working out of inherited tendencies eventually becomes a soldier and an officer upon General Washington's staff, is most charmingly told, and is the best of Dr. Weir Mitchell's always readable books. The scene is laid in Philadelphia, about the time of the American Revolutionary War, and the author effectively reproduces the local coloring and the action of this stirring period of our national history, and many of the great historical characters are prominent in the story. Dr. Mitchell spent much time and labor in the preparation of this work, studying the scenes of his story and familiarizing himself with the details, and becoming so imbued with the spirit of the time that he writes with almost the ease and assurance of one who was actually engaged in the scenes he depicts. The book is interesting from many points, as a notable contribution to the history of a momentous period, as showing the working out of inherited traits, and as a study of character and for the charming love story which runs through the book.

THE INTERNATIONAL MEDICAL ANNUAL, for 1898, E. B. Treat & Co., now nearly ready for publication, will contain many special articles of great interest in addition to the regular summaries of the year's work in medicine and surgery.

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Lachesis in Dysmenorrhea.—Dr. Dahlke.—General amelioration as soon as the secretions appear, toothache during menstruation; the less the flow the greater the pain.

Cannabis Indica in Threatening Abortion.—Dr. Danforth.
—Theatened miscarriage, with discharge of blood from vagina, in eighth month of pregnancy; burning in making water with purulent discharge—gonorrhea.

Zincum in Leucorrhæa.—Dr. Ward, Paf. Coast Jour.—Zincum is indicated with thick or bloody leucorrhea, causing an itching preceded by cutting colic. Left ovarian pain, relieved during menstruation. Third trituration.

Causticum in Enuresis.—Dr. Waldran, in Am. Journ.—Causticum, feeble constitution, paralysis if from long retention involuntary passage from coughing or sneezing, burning in urethra when passing, turbid on standing.

Belladonna in Menorrhagia.—The local symptoms are pronounced; great soreness and sensitiveness over womb and ovaries; bearing-down sensations, as though everything would fall out; blood bright red; patient very irritable, nervous.

Silicea in Mammary Abcess.—Dr. Richardson, St. Louis Jour.—In cases where phosphorus is not sufficient to treat the fistulous opening, with callous edges; or to disperse the hard lumps in the breast; or where the discharge is serous.

Thuja in Diarrhea of Children.—Dr. Gaston, Med. Coun.— Thuja has copious, pale yellow watery stools, discharged with great force and gurgling. Croton tig. has this same characteristic in the discharge of the stool, and also great debility. The diarrhea of croton tig. is painless.

Cantharis in Albuminuria of Pregnancy.—Dr. Christine, Hahn. Mon.—Cantharis is indicated in acute and recurring attacks of nephritis. Cantharis is not a specially albuminous remedy, but is useful in acute congestions or inflammations of the kidneys, and particularly in simple renal insufficiency with bladder symptoms.

Creasotum in Leucorrhæa.—Dr. Allen.—Leucorrhæa, painful pressure toward the genitals, with stitches from small of the back,

leucorrhœa becoming acrid and watery or even ichorous, bloody, with purulent, offensive smell; coition very painful, with fear and trembling; all the symptoms worse during menstruation, cervix seems hard and painful and everted, with cauliflower excresences.

Sulphur in Rachitis.—Dr. Payne.—Sulphur meets the rhachitic symptoms. In sulphur there is defective assimilation. The child has a voracious appetite: it greedily takes everything that is offered as if it were starved; and still it is always hungry and looks emaciated. The food is not appropriated for the nourishment of the body.

Iodine and Bromine in Croup.—Med. Counselor.—In differentiating between iodine and bromine, note that iodine in its general influence is excitant, while bromine is depressant. Hence iodine is claimed to be preferable in sporadic croup in previously healthy subjects, while bromine is more useful when the false membrane in the air passages is produced by the diphtheritic poison.

Rhus Toxicodendron in Backache.—The thought of rhus tox., together with the icy sidewalks, is enough to cause one to feel its typical pains, which are of a stiff, lame, bruised, dull, aching kind, better from motion; extended heat. The expression "a violent pain, as though back were broken" describes the pain. Uterine complaint from exposure to cold, damp weather, from getting wet, particularly while perspiring.

Æthusa in Diarrhea.—Dr. Ealer, Hahn. Mon.—Æthusa 2x or 3x. Our chief indication is the character of the vomiting, which is very forcible, throwing the milk and stomach contents away from the child like water issuing from a fire-plug. Immediately or soon after the child will take the breast or bottle again, with probable repetition of vomiting.

In cases of cholera infantum, the child lying in a stupor or spasms, with sunken fontanels, clinched thumbs, cold surface of the body, etc., our experience has not been flattering to æthusa.

Lycopodium in Suppression of Menses. — Dr. Powell.—Mrs. P. Clinical symptoms: Sudden suppression of the menstrual flow from fright, with violent pains all over the abdomen and intense restlessness, rolling over the bed from side to side. Remarks: She could not keep her head still enough for me

to put it on her tongue, so I gave her the vial to smell. In fifteen minutes she went to sleep. Awoke in two hours with some pain, smelled the vial and was relieved perfectly. Menses did not return until eighteen hours after pain ceased, and then proceeded without any distress.

Creasotum in Backache after Abortion.—Dr. Klapp, Clinique.
—This patient came to me the first of July complaining of backache in the small part of the back. She informed me that a midwife had produced an abortion for her in April. My patient was slender, very pale, and told me she had no appetite, and felt languid all the time. She had leucorrhœa, and the odor emanating from this woman was most vile. It was so disgusting that her friends could not remain in the room with her, and she had become a social pariah.

On examination I found in the posterior cul-de-sac a rotten slippery elm tent, one that had probably been used to produce dilation of the cervix uteri; this I removed, the vagina was then thoroughly cleansed, and made aseptic by the use of hydrozone. Then with iodoform gauze the uterus and cervical canal were mopped out, and the vagina again cleaned, and packed with iodoform gauze. Creosotum 3x given four times a day. The 5th of July the patient reported that there was but slight leucorrhæa and no odor. Creosotum 3x. The 9th of July, no leucorrhæa, no odor. Slight backache, with a tired feeling. China 2 was given the 15th of July; no backache, the tired feeling all gone, the appetite good, and sleeping well.

Phytolacca in Scarlet Fever.—Dr. Conzelman, St. Louis Journ.—As in diphtheria, so in scarlatina the throat symptoms are the ones most likely to attract the prescriber's attention.

The tonsils and fauces are much swollen and are dark bluish red and ulcerated, the right side being most affected—uvula is large and cedematous. This cedema at once suggests apis. The fact that both remedies present albuminuria and suppression of urine may further assist in the confounding.

Differentiation is readily made from the bright redness of the apis throat and the absence of the intense fetor so characteristic of phytolacca. The two other throat symptoms of phytolacca are the extreme sensitiveness of the neck to the touch and the aggravation caused by hot drinks—just as in lachesis, excepting that here the symptoms are left-sided. Phytolacca presents an

acrid, excoriating nasal discharge suggesting also arsenic and arum tri. The tongue is peculiar, and I think characteristic of phytolacca, showing a comparatively clean but dry center, the sides being coated brown. Pulsatilla has dryness of the center of tongue, but it is entirely subjective—I have seen it a number of times.

The eruption of phytolacca is of the miliary variety, the skin is dry and shriveled—feels like brown paper. These symptoms coupled with great restlessness and rheumatism of the joints call to mind rhus tox., but it possesses none of the angina and fetor.

Drosera in Whooping Cough.—Dr. Dewey.—Drosera is one of the remedies praised by Hahnemann; indeed, he once said that drosera 30x sufficed to cure nearly every case of whooping cough, a statement which clinical experience has not verified. Drosera, however, will benefit a large number of cases if the following indications be present: A barking cough in such frequent paroxysms as to prevent the catching of the breath, worse in the evening. All efforts to raise the phlegm end in retching and vomiting. The attacks are especially worse after midnight. Bayes says: "Drosera is more useful in whooping cough than any other remedy in our materia medica." Unlike Hahnemann, however, he claims that the higher dilutions are powerless, and he prescribes the first. Drosera acts better in pure, uncomplicated whooping cough, and while it will correspond to some epidemics, it will fail in others.

Helonias in Gynecology.—Dr. Dewey, Med. Cent.—There are two special indications for this remedy in female complaints, namely, atony of the genital organs, and pain extending from the back to the uterus. The key-note leading to its selection has ever been a "consciousness of a womb." Probably in affections of the uterus calling for other remedies there is a consciousness of a womb, but here the consciousness consists of a soreness and weight in the womb, which is constant; there is no let-up to it, and there is accompanying a tired, aching feeling in the back and limbs; in such cases helonias acts as a uterine tonic.

Helonias is a useful remedy in leucorrhœa which is dark, offensive, and constant; it flows on every exertion. General debility is marked and pruritis may accompany.

The menses are too frequent and too profuse, and the flow is passive, dark, coagulated, and offensive. Abortion from the

slightest over-exertion, and sterility due to great debility, may call for helonias.

Displacements of the uterus also find their remedy in helonias, with heaviness in hypogastrium, a tired dragging feeling in the back, which, upon slight exertion, extends all over the body.

Debility and anæmia are characteristic of the remedy. There is a general atonic condition of the whole system, and this is quite apt to make the patients hypochrondriacal and low-spirited.

Platina in Diseases of Women.—Dr. Dewey, Med. Cent.—Leading up to this remedy we always have the mental symptoms, though it is not clear why the mental symptoms are more important in the case of platina than with other drugs. The mental symptoms of platina are, however, very characteristic and recall the drug at once whenever found; the pride, the haughtiness, the self-esteem, and the belittling of everyone are found accompanying female complaints quite often. Then, too, remember the strange feelings, in which home objects seem unfamiliar; also the melancholy.

The menstruation of platina is profuse and clotted and occurs too early, with much sensitiveness about the genital organs. There is constant irritation about the sexual organs, both internally and externally. There are often present symptoms of nymphomania. There is also accompanying menstruation much painful bearing down in the uterine region. The menses of chamomilla are very similar to those of platina, the mental symptoms distinguishing.

Platina also is a remedy for induration and prolapsus of the uterus where there is continual pressure in the groins and back, with sensitiveness of the parts to the touch. It is also one of the remedies for painful coitus; others being sepia, belladonna, creasote, and apis.

Antimonium Crudum 3x in Broncho-pneumonia.—Dr. Leonard.—Child, æt. eighteen months, was brought to my office to see if I could not fix its rupture, that had been keeping it sick for nearly two weeks. On examining a slight umbilical protrusion I discovered that the temperature in the axilla was 103½°, and that it was suffering from broncho-pneumonia. Sounds could be heard all over the chest. Child was hardly able to sit up and too sick to show its mentality. The first prescription was ineffective and the next day the lungs were unchanged. Tem-

perature one-half a degree lower. Very cross and irascible and would not sleep unless rocked. Gave chamomilla 6x, but on succeeding afternoon found patient about the same, but had slept quietly all night. Fever had returned about noon. Temperature at 4 P. M. was 102½°. We had to take it by main force and agility. While studying cham., cina., ant. crud., ant. tart., bry., and nux., a neighbor remarked: "Why, that baby won't let me even look at it; when I look up it jerks its head the other way." That settled it; I then gave ant. cr. Clinical symptoms: Child cannot bear to be looked at. Extreme irritability and fretfulness. Remarks: a powder every two hours when awake. Improvement immediate and convalescent two days later.

Nux Moschata in Prolapsus Uteri.-Dr. Neatby, in the Mon. Hom. Rev.-Mrs. G., æt. thirty. Has suffered for many years "from prolapsus uteri." The trouble is constantly brought on by exertion even of trifling character. A comparatively short walk is enough to cause a "descent of the womb." She had worn two ring pessaries, but had discontinued their use as she was unable to retain them. They came out with every motion. suffers from constant pain in the back below the waist, and from a dragging pain from the shoulders downward. The pain is worse just before each period, but there is no pain during the period. She has no bearing down sensation. The period is sometimes seven days too soon, and sometimes fourteen days too late, and is occasionally profuse. She frequently has a troublesome leucorrhœa for a week before the period. There is an occasional headache right through the temples, just anterior to the ears. complains also of pain at the back of the neck. She sleeps well, but gets drowsy by about 9 P. M. She has long suffered from palpitation, which is worse on exertion or on going to bed. There are no dyspeptic symptoms, no "globus" or faintness, but sometimes numbness of fingers.

Nux moschata 4x, m. iii. ter. Ten days later reported. Altogether much better. Feels very little of the pains in the back, and nothing of the pain in the neck. Has entirely lost the nervous, restless feeling she had. Has much less palpitation but still some headache. The leucorrhœa has disappeared. There has been no return of the prolapse, though the patient has frequently made such exertion as always formerly sufficed to bring it on. The last period came on prematurely.

July 27. One month later reports herself as better than she has been for a great many years. The leucorrhœa is better. She is free from the pain in the back and continues entirely free from the prolapse, though working harder than when she was constantly suffering from it.

No local treatment has been adopted in this case. There has been no change of air or rest of any kind. During the treatment the patient's circumstances have been getting more and more trying.

Cimicifuga and Caulophyllum.—Dr. Cowperthwaite, N. A. Jour.—The chief point of difference between these two drugs is that while the cimicifuga is a depressing irritant it produces persistent tonic contractions or spasms, and that caulophyllum, likewise a depressing irritant, produces intermittent or clonic spasms, soon followed by complete atony. Tonicity is therefore characteristic of the one, while atony is equally characteristic of the other. This action is especially exemplified in the uterine sphere, and it is here that we find the chief and almost only point of differentiation between the two drugs. In cimicifuga the action seems to come through the direct influence of the spinal nerves. which is not so evident in the action of caulophyllum. the former covers a large range of reflex disturbances in the ovario-uterine sphere in which caulophyllum is practically useless. On the other hand, too, cimicifuga produces many reflex disturbances in various parts of the body, especially in women, due to ovarian-uterine irritation, which is not the case with caulophyllum. These reflex disturbances are of a neurotic character, such as neuralgia, chorea, epileptiform convulsions, etc., in the treatment of which caulophyllum forms no part of our curriculum. Cimicifuga constitutes one of our most useful remedies in the treatment of suppressed, tardy, or irregular menstruation, especially when accompanied by reflex nervous disturbances. Caulophyllum is useful in too profuse and too frequent menstruation, the flow being passive in its character. However, caulophyllum may at times be indicated in suppression of the menses, where there is great atony of the organs, or where clonic spasms of the uterus are present, and cimicifuga may prove useful in rare cases of menorrhagia when the blood is dark and clotted, with severe persistent pain extending through the hips and down the thighs. Caulophyllum is of greatest value in the treatment of passive hemorrhage following abortion or confinement, due to atony of the uterus. Both are valuable parturifacients; cimicifuga is indicated for the so-called "false" pains, when they do not force downward, but shoot upward and across the abdomen. If caulophyllum is indicated the pains are weak and do not force downward, but pass off with a kind of shivering. Cimicifuga also gives "shivers" during the first stage of labor, but not associated with the weak, atonic condition which indicates caulophyllum. The latter is said also to dissipate the annoying pains which sometimes occur for weeks before confinement, and apparently threaten premature delivery.

Both are useful in threatening miscarriage, cimicifuga with flying pains, and caulophyllum with clonic uterine spasms and hemorrhages. Either remedy may be called for when there is a "rigid os," but cimicifuga is oftenest required; both are useful for afterpain, but cimicifuga is oftenest indicated, the pains being severe, and the patient becoming so sensitive to them that she is almost if not quite hysterical. Caulophyllum is more often needed for afterpains following an exhaustive and tedious labor. Both are useful in sub-involution, but as the condition is one of atony caulophyllum is most often called for. Such is also the case when a protracted lochia exists due to the same cause. Both remedies are valuable in dysmenorrhea, but cimicifuga is far oftenest indicated. Indeed with the exception of viburnum, no remedy in the whole materia medica can compare with cimicifuga in this direction. The dysmenorrhea is rheumatic or neuralgic in character, with bearing down in uterine regions and small of back; limbs feel heavy and torpid. Sometimes shooting pains, Often hysterical conditions. With caulophyllum there may be and often is spasmodic pain in the uterus and hypogastrium, but more often the pain is as if the uterus were congested and heavy.

Caulophyllum is often a valuable remedy in prolapsus uteri and in retro- and anteversions, when the displacement is due to atony of the organ. Cimicifuga is rarely useful in uterine displacements. For the same reason leucorrhœa rarely calls for cimicifuga unless accompanying symptoms so strongly indicate the drug that the abnormal discharge becomes of secondary consideration. Caulophyllum is indicated for a profuse leucorrhœa resulting from atony of the mucous membrane.

Chnecolodical Plassinds.

Cocaine Anæsthesia in Perineorrhaphy.—Dr. Humiston, Virginia Med. Semi-Mon.—Ten years' experience of cocaine anæsthesia in minor gynecological surgery, and especially in curetting, trachelorrhaphy, and the repair of the perineum by Tait's split-flap operation, has always given satisfactory results, and one thus avoids the long-continued vomiting which so often follows the use of chloroform or ether. The maximum quantity used is fifty minims of a two per cent. solution, equal to a dose of one grain. Thirty minutes before the operation $\frac{1}{2}$ ounce of whisky or brandy is given, followed by the hypodermic administration of $\frac{1}{30}$ grain of strychnine. The margins of the area of operation in perinorrhaphy are systematically gone over with the hypodermic syringe containing the cocaine, so that the drug is equally distributed in the tissues, and the whole field anæsthetized.

Tubal Gestation. - Dr. Dührssen, Archiv. f. Gynäk. - The most frequent cause of tubal gestation is gonorrhea through the catarrhal salpingitis which that disorder sets up, although polypus of the tube may likewise cause the same phenomenon. tubal sac, on the uterine side of which lies a small polypus which obstructed the lumen so as to prevent the fertilized ovum from passing into the uterus, was also a cause. The ostium is very patulous. A less familiar condition is the cause of tubal pregnancy when evidence of inflammation or mechanical obstruction is absent. In seven cases the abnormal followed within a year a normal pregnancy. A careful examination of the tube in one of these cases showed the most definite evidence of atrophy of its walls. This puerperal atrophy damages the peristaltic action of the tube, and as the lumen is dilated the entry of spermatozoa is favored. The weakened tube then fails to propel a fertilized ovum into the uterus.

The Treatment of Vaginitis.—Dr. Gutherz, Clin. Rec.—In acute vaginitis under homeopathic treatment a cure may be anticipated; but in chronic cases, when the follicles of the vagina are hypertrophied and pour out an abnormal discharge, the prognosis is less assuring. In treatment the aim must be to reduce inflammation and build up the system and thus lessen the tend-

ency to take cold, and by local means to quiet pain and irritation Absolute rest in a horizontal position is essential, and good frequently results from injections of warm water, bran-water, hydrastis and glycerine (one dram to the ounce, in one pint of tepid water) thrown into the vagina three times a day. Remedially, aconite is most frequently indicated in the fever of the first stage, with dryness of the vagina and rigors up and down the back; or belladonna, when there is great heat and soreness and dread of being touched. Cantharides will be thought of if there be dysuria; arsenicum when the discharge is excoriating and the patient is subject to profuse menstruation; carbo vegetabilis and mercury solubilis in an ulcerated condition of the vagina; sepia when leucorrhœa is profuse after micturition, the discharge being corrosive and fetid, and inflammation having extended into the urethra; cimicifuga when there is intense pain in the ovaries and in rheumatic subjects. In the specific variety, involving the urethra, vagina, and vulva, and caused by the absorption of the poison, and where there is danger of the morbid action passing up into the uterus and causing endometritis, or into the bladder and causing cystitis, or leading to the formation of labial abscess, aconite forms the advance guard, with cannabis sativa, cantharis hepar sulphur, and mercurius iod. forming a solid phalanx about it. In the diphtheritic variety, carefully consider the mercuries, arsenicum, apis, lachesis, and nitric acid; for the prognosis in this form of vaginitis is necessarily grave.

Fecal Impaction of the Sigmoid Flexure in Women.—Dr. Bacon, Chicago Med. Rec., has found in several cases that were sent to him for abdominal operation, simple fecal impaction of the sigmoid flexure accompanied by local pain, backache, and such severe tenderness that a satisfactory examination was only possible under anæsthesia. Cure was effected by the conjoined use of laxatives and high enemata. In all the uterus was relatively normal at least, and the right ovary and tube as they should be. The sensitive mass on the left side, however, closely simulated a tender pus tube, an inflamed or otherwise diseased ovary, or a pelvic exudate. But the clearing out of the sigmoid with a laxative and a high enema invariably permitted the demonstration, under anæsthesia, of a normal tube and ovary on the left side.

Physiological Effects of Castration in Women.—Removal of the ovaries arrests menstruation immediately in only 62 per

cent. of cases; 20 per cent. menstruate irregularly during the first twelve months, while in 17.5 per cent. of cases menstruation continues, and may be even profuse and intractable. The cases in which menstruation persists is explained by the supposition that the removal of the ovaries was incomplete. After removal of the uterus, menstruation is very rare, but several cases have been recorded in which a periodic loss occurred after hysterectomy, and in these cases it is probable that a portion of the tube has remained in communication with the vagina. Wendeler has recorded a case of hysterectomy in which pregnancy afterward occurred in the stump of a tube which had remained permeable.

The following formidable list of functional disturbances may be met with after castration: flushings; loss of memory; neurasthenic symptoms; alterations of character; congestive and hemorrhagic phenomena (epistaxis, hemoptysis, etc.); disturbances of nutrition; disturbances of the special sense organs; mental troubles. These disturbances are constantly met with after ovarian castration, although they vary much in severity in different cases. After removal of the uterus alone, on the other hand, they are very rarely met with, and never become really severe. It seems therefore clear that they are due to the absence: of the ovaries, rather than to the suppression of menstruation, a fact which only seems explicable by the theory that there is an internal ovarian secretion which plays an important part in the nutrition of the nervous system. The only treatment which offersany chance of relief is the administration of ovarian extract. Both ovaries should never be removed except in cases of organic: disease, which renders castration absolutely necessary.

Post-Climacteric Conditions that Simulate Advanced Uterine Cancer.—Dr. Rosenwasser.—Irregular hemorrhages and sero-sanguinous discharges, whether occurring during the parturient stage or long after the menopause, are good and sufficient reasons to suspect malignancy. We carefully watch for early symptoms, and by their detection occasionally succeed in removing the disease while it is still local. On the other hand, we are sometimes caught off our guard when confronted with post-climacteric cases presenting all the classical characteristics of advanced malignant disease. Without the same circumspection exercised in the early stages, we thoughtlessly pronounce the case beyond remedy or hope, specifying even the extreme possibility of

life. The text-books are deficient in not sounding a note of warning against possible errors in the late stages. The so-called classical symptoms may be due to other (non-malignant) conditions of the genital tract. Owing to effacement of the vaginal portion of the cervix in old age, the differential diagnosis is in most cases limited to corporeal diseases of the uterus. Before the diagnosis of corporeal cancer can be made other diseases must be excluded.

The conditions which are likely to simulate advanced cancer are: senile vaginitis; foreign bodies in the vagina; gangrenous fibroids; atrophic, senile, or post-climacteric endometritis; and post-climacteric pyometra. Of these conditions the last is especially liable to lead to errors.

In conclusion attention is called to the singular fact that in the presence of the essential predisposing conditions—age, low vitality, cicatricial tissue, adhesions, chronic inflammation, and irritating discharges—cases of transformation into malignant disease are either unknown or exceedingly rare.

Precocious Puberty.—Dr. Brohl, Centralbl. f. Gynäk., reports the case of a girl, aged seven, who, according to her mother, had menstruated two months running. He saw her a month after the second period, or pseudo-period. There was a free growth of pudendal hair, though otherwise the subject seemed still a child. He was consulted because the patient's abdomen was getting larger. He found the parietes tense, with universal dullness. A large cystic tumor of the left ovary was removed; there were but few adhesions. Its contents were dark and glairy, and numerous secondary cysts sprang from its inner wall. The operation was performed in February, 1895. Down till January 16, 1897, when the case was reported, the period had never reappeared.

Menstruation and Nutrition.—Dr. Keller, Archives Générales de Médecine.—Menstruation has an undoubted and quite direct influence on nutrition. There is a marked diminution of urea and of nitrogenous materials incompletely oxidized, and a distinct augmentation of Robin's coefficient of oxidation. The elimination of nitrogenous products in the urine is influenced by relative scantiness of the catamenia. Menstruation is accompanied with a diminution of the destruction of albumins in the system. The oxidation of nitrogenous products attains its maximum. The products of nitrogenous waste are eliminated least

freely during the days midway between two normals periods. Menstruation is simply the indication of a periodical movement which runs through the active sexual life of a woman, and is associated with all her functions. These researches confirm those of Goodman, Stephenson, Jacoby, Van Ott, Rabuteau, Hegar, Reinl, and Schrader.

Indications and Use of the Uterine Sound.—Dr. Rosenwasser, Atlantic Med. Weekly.—a. To ascertain the degree of patency of the cervical canal; to explore the condition of the mucous lining of the cavity, and to measure the depth of the uterus.

Those who discard its use cannot point to a single symptom by which a stenosis can be demonstrated without sound or probe; nor can they help us discover the sensitiveness or hemorrhagic tendency of the mucous lining; nor can they adduce other means by which an accurate knowledge of the size and shrinkage of the womb in subinvolution can be obtained. Furthermore, they cannot assign any reason why the proper use of the sound should be especially calamitous when the similar use of like instruments in organs even more sensitive is conceded to be most appropriate and surgical.

b. To define the position of womb in the pelvis and the relation of the cervix to the body when these cannot be accurately established by the bimanual.

The sound will clear the doubt in the case of a fleshy woman through whose fat abdominal wall we think we feel the fundus or fail to feel it.

c. To induce early abortion. Experience has taught many of us how easily an unwitting use of the sound can bring on the discharge of an impregnated ovum. Following this cue I have used the sound within a few days after missed menstruation in cases where a possible pregnancy was deemed inadvisable or dangerous. The sound is introduced to the fundus and allowed to rest in the uterus one or two minutes to induce imperceptible contractions. A reintroduction after a few days will usually effect a safe discharge.

d. To assist in replacing some cases of retroversion.

Reposition can be effected in most cases by bimanual manipulation. A patient who is very nervous, or one whose abdominal wall is very thick, cannot thus be managed. The sound is here

a valuable aid. It is introduced through the speculum and held in place by the right hand while the speculum is being removed over it with the left. The left index-finger is then placed into the posterior vault, pushing the fundus upward and forward while the handle of the sound is being depressed. The vaginal finger thus guards against injury and facilitates the replacement.

I would not recommend the sound where of doubtful utility or where an anæsthetic would better establish a diagnosis, or where the procedure might be attended with danger. For instance, in differentiating retroflexion from retro-uterine tumors, or uterine polypus from inversion; or in efforts to locate interstitial fibroid in either wall in the presence of a tortuous canal.

Flooding at Puberty.—Bécigneul, Lancet, reports a case of a girl of thirteen attacked with profuse uterine hemorrhage. first period began with the usual phenomena, but the show lasted a fortnight, and after an interval of a week reappeared and continued for a fortnight, when Bécigneul was consulted. Rest, cold drinks, and ergotine were of no avail. The parts were explored, and the uterus and ovaries appeared to be thoroughly well developed. An intra-uterine injection of water at 113° F, at last stopped the flooding, which was becoming serious. Five days later the patient got up, the bleeding recurred, and an injection was thrown up into the uterus. The flooding ceased, but not so quickly as before. For a month the patient was kept in bed, and the injections were continued daily. Menstruation was afterward definitely established. This patient seems to have suffered from the idiopathic metrorrhagia occasionally seen in young subjects. Bécigneul found that she had no sign of hemophilia besides the bleeding, no cachexia of any kind, and no heart or liver complaint. She had never been attacked by any infectious disease; diabetes, albuminuria, and inherited syphilis were excluded, nor was there any evidence of poisonous diet. The uterus showed no sign of disease. The above negative history appears to be the rule in this flooding at puberty or "metrorrhagia of adolescence." Bécigneul admits that the theory of reflex irritation as a cause explains nothing.

Producing Sterility by Section of the Fallopian Tubes.— Dr. Fritsch.—This operation is often desirable in making a vaginal fixation of the uterus to avoid the dangers of labor. The vagina is opened longitudinally in the typical manner, the bladder separated, and the angle of the uterus drawn into the wound. The tube is ligated with catgut in two portions, and a piece half an inch long removed between the two ligatures, and repeated on the opposite side. The typical vaginal fixation is then performed. I intentionally resect a portion of the tube, as I found, in an earlier case, after I had performed a laparotomy and myoma enucleation from the uterus, and had tied both tubes firmly in the middle with silk, but did not divide the tubes, that the woman became pregnant three years later, and had a normal labor. I have also observed, after ligating the intestine in dogs, that when the animal did not die from ileus, the intestine swelled up and became adherent over the ligature—as with a Murphy's button—and the canal formed again. A similar condition might have taken place with the fallopian tubes.

Retrouterine Displacements.—Alexander's operation of shortening the round ligaments has been a favorite operation, but its uncertainty and unfortunate sequelæ have made many doubt the wisdom of performing it who have had abundant opportunity to follow up the cases afterward. The more progressive operators, as a rule, have abandoned it in favor of some of the operations from the vagina, such as the shortening of the round ligaments from below by Wertheim's method, a modification of uterovaginal fixation, or the new operation of Mackenrodt, in which he sews the peritoneum of the bladder to the fundus of the uterus, and fastens the denuded surface of the bladder to the anterior wall of the uterus. According to Dr. Mackenrodt, the operation has been invariably successful in more than one hundred cases, without mortality and without a single recurrence.

Surgical Treatment of Peritonitis in Women.—Dr. von Winckel.—The exact method of intervention will of course vary according as the affection is of tubercular, gonorrheal, post-operative, or puerperal origin, or due to rupture of an ovarian abscess, to putrid decomposition, of hematomata or of hydatid cysts, to torsion or gangrene of fibromyomata or of ovarian tumors.

Tubercular peritonitis is amenable to abdominal coeliotomy. The incision must be made in the median line or through the left rectus abdominis and measure from 10 to 20 centimeters in length. Anterior colpo-coeliotomy is not a good operation in this variety of the disease, owing to the insufficient dimensions of the

incision. I may add, in respect of tubercular peritonitis, that it is not safe to consider it cured, unless the patient has been kept under observation for a sufficient length of time after the operation. I have seen cases in which the disease recurred five years after the surgical intervention.

Gonorrheal peritonitis does not give rise to any extensive exudation nor to any particularly threatening symptoms; it does not as a rule call for surgical intervention. An operation only becomes necessary in the presence of pyosalpingitis; abdominal cœliotomy is then indicated when the purulent collection is of large size, anterior colpo-cœliotomy when the abscess is of small dimensions. In cases of gonorrheal peritonitis consecutive to perforation, laparotomy is always indicated.

Post-operative peritonitis requires that the abdomen should again be opened partially, so as to evacuate the pus. General irrigation is contra-indicated, but free drainage must be insured-

The surgical treatment of diffuse puerperal peritonitis raises several questions which it is as yet impossible to answer: should the intestine be taken out of the abdomen, the cavity washed out and the walls sutured? The few cases of puerperal peritonitis hitherto operated upon appear to show the necessity of interfering as soon as the purulent effusion becomes copious, on condition that the pleuræ and pericardium be not involved. The abdominal wall must be incised freely and the peritoneal cavity drained. The majority of surgeons are in the habit of washing out the peritoneum.

Peritonitis by perforation, lastly, can only be cured by abdominal laparotomy. The ruptured or putrefied organ must be extirpated.

Atrophy of the Female Genital Organs.—Dr. J. Fischer.—Congenital atrophy of the uterus differs from acquired atrophy, the former not being atrophy in the strict sense of the word, but arrest of development. With regard to the latter form, a distinction must be made between different varieties of acquired uterine atrophy, physiological and pathological, puerperal and non-puerperal, primary and secondary.

Among visceral diseases, tuberculosis most frequently gives rise to atrophy of the uterus, although this is not by any means a constant symptom of tuberculosis. Moreover, there is no relationship between its occurrence and the state of nutrition, stage of the disease, or pyrexial conditions. This atrophy is met with in normal subjects as well as during the puerperium. The ovaries shrink and become wrinkled; the atrophy of the uterus develops concentrically, being always less marked in the vaginal portion of the cervix and in the vagina. Histological examination shows in the ovaries proliferation of the connective tissue and atrophy of the follicles; in the uterus thinning of the walls and mucous membrane, and frequently inflammatory changes in the cervical mucosa.

The clinical symptoms of genital atrophy consist in arrest of the menses, menorrhagia, metrorrhagia, etc.

The causes of acquired genital atrophy are frequently toxic in their nature. Such are atrophies following thyroidectomy, Graves' disease, chronic morphinism, diabetes, etc.

Another group of genital atrophies is formed of those following acute infective diseases, such as enteric fever, acute articular rheumatism, scarlatina, and influenza. These are due to inflammation of the ovaries, which are enlarged and tender to pressure, whereas the uterus is atrophied. This atrophy may disappear after the cessation of the oöphoritis. The same lesions may be determined by ovarian hemorrhages, such as are observed in cholera, enteric fever, septicæmia, etc.; but in a large number of cases atrophy met with in infectious diseases is really of toxic nature. Chronic alcoholism and poisoning by phosphorus, arsenic, or mercury are also liable to determine genital atrophy.

This process is likewise met with in paraplegia, certain forms of psychosis, etc. Chlorosis does not determine genital atrophy, but is frequently associated with arrest of development of the genital organs. Atrophy accompanying obesity appears to be dependent on abnormalities of the thyroid gland, and belongs therefore to the group of atrophies of toxic nature. Simpson has called attention to the existence of genital atrophy in Addison's disease. The atrophy met with in acromegaly has not as yet been satisfactorily accounted for.

Laparotomy in Extra-uterine Prognancy at Term.—Dr. Gallez.—Cases of extra-uterine pregnancy continuing to full term are very rare; those ending in abdominal extraction of a living child are exceptional. On this account, a case reported by Dr. Charles, Liège, is of unusual clinical interest, because it furnishes important hints for the treatment of the placenta after cœliotomy

and extraction of the fetus, and especially for the conduct to be adopted in certain favorable cases of ectopic gestation.

The patient was a primipara, thirty-five years of age, in whom Dr. Charles recognized the presence of an extra-uterine fetal cyst. She was admitted into his wards at the Maternity of Liège. Having kept her under observation constantly for two months and a half, he performed laparotomy at term, extracting an infant, which weighed 2800 grams, and measured 48 centimeters in length. The placenta was left in place and covered with tannin and salicylic acid, the cavity being marsupialized.

The patient made an uneventful recovery after this delicate operation. The placenta was eliminated piecemeal, without the least decomposition, from the thirtieth to the fortieth day.

It is a curious fact that this woman, who was operated on February 12, 1896, became pregnant again in July, that is to say, five months later. This time the pregnancy was uterine and developed normally. She was again admitted into the Maternity, where she was delivered with forceps, on April 25, 1897. The child weighed 3450 grams and measured 51 centimeters.

At present both children, a boy and a girl, are in excellent health, as well as the mother.

Metrorrhagia in Diseases of the Liver.—Dr. Dalché.—It has long been known that diseases of the liver are frequently the cause of metrorrhagia. It results from my researches that, of all hepatic affections, biliary lithiasis exerts the greatest influence on menstruation. As the result of an attack of hepatic colic, the menses usually become more abundant and last as long as ten or twelve days. This menorrhagia is frequently associated with expulsion of clots and pain, similar to that observed in congestive dysmenorrhea. After several attacks of colic, the catamenial periods may be precipitated, delayed, or even cease altogether, so that there is no longer any regularity in the appearance of the menstrual flow. Abortive or attenuated attacks of colic may give rise to the same changes in the menstrual periods.

The hepatic cirrhosis at the onset determine metrorrhagia, which later on leads to amenorrhea. Lastly, I have on several occasions met with metrorrhagia in the course of hepatic tumors and benign or malignant infective jaundice.

Common Affections of the Female Urethra.—Ec. Med. Jour.—The female often complains of pain, irritation, and suffer-

ing, referable to the urethra. This may occur during the progress and treatment of some additional trouble or exist and require attention independently. Such symptoms usually depend upon or immediately follow micturition, and may be due to various causes, which should be ascertained by a careful examination and inspection, owing to the permanency of the symptoms and various reflex disturbances, if allowed to go unheeded or not properly treated.

One of the most common of the acute affections, which is quite frequently encountered, is urethritis—inflammation of the urethral canal. While gonorrhea is likely to be suspected in such cases, nevertheless, the non-specific or simple form is not uncommon. Polyuria, attended by severe pain, burning, and vesical tenesmus, is a common symptom. The presence of the urine not infrequently causes the highly sensitive and irritated tissues to contract, resulting in spasmodic action of the canal, and interrupted and embarrassed micturition—a most distressing symptom. The urethral tissues become indurated and sensitive, and may be traced or outlined with the finger, along the anterior vaginal wall. The temperature is usually somewhat elevated, which, together with the location and effect of the pain, readily determines the trouble.

Veratrum and gelsemium, as a rule, meet the indications, and in addition to vaginal douches, as hot as can be endured, will prove beneficial in the acute attack. The burning and distress in passing the urine may call for apis, rhus tox., or erigeron, as well as the local application of hot fomentations.

Urethritis usually arises from cold or exposure, or the causes that generally produce catarrhal inflammation. It will generally yield within a short time if quietude is enjoined, in addition to the specifically indicated treatment. When the acute inflammation persists, either owing to want of efficient treatment, or negligence and continued exposure, the chronic form is likely to follow.

In the chronic variety, while the suffering is not so severe, there will be in addition the muco-purulent discharge. In this stage the urethra should be cleansed by the use of warm carbolized water, after which an injection of fluid hydrastis should follow, one part to sixteen of water, twice daily. No internal treatment will likely be called for, other than to keep the bowels in normal condition.

Another form of trouble and source of irritation frequently

found, in married women especially, is a form of neoplasm known as urethral caruncle. These small tumors are usually severely aggravating. They vary in size from a pin head to a hazelnut, and are generally found upon the posterior wall and outer half of the urethra. Often a group of them may be found just within the meatus or projecting outward. They result from a varicose condition of the capillary vessels, are very red and granular in appearance, bleed upon the slightest irritation, and are very sensitive. The contact of the urine in micturition excites very severe suffering, coitus is often painful, owing to pressure along the urethral canal; slight hemorrhages are likewise not uncommon. Various reflex neuroses frequently attend the presence of this form of trouble, such as headache, backache, general nervousness, and irritation. Difficult and painful urination is a condition from which there is frequent complaint. They may occasionally attain sufficient size to obstruct the urethra; in other cases closure of the canal results from severe spasm due to the excruciating pain attending micturition.

This is the most common of the various lesions of the female urethra, and may be suspected in a case presenting the foregoing suggestive symptoms. The suspicion will be confirmed and the diagnosis easy from the appearance of the parts upon examination.

Owing to the extreme pain and distress attending this condition, prompt and proper treatment should be instituted without delay, which consists in the removal of the growths. The patient should be chloroformed and placed in the lithotomy position, after which the easiest means of removal will be found in excision with the scissors. Those most nearly external should be first removed, after which, by means of the urethral speculum, those higher up may be revealed, and in a like manner excised. The currette can likewise be used to insure the removal of all traces of the trouble. It is advisable to cauterize the base after extirpating the larger neoplasms.

The patient should observe quietude, normal action of the bowels, and a light diet for a week, when the usual uninterrupted convalescense soon restores to the woman relief, comfort, and health

Pediculated tumors, or urethral polypi, are also occasionally seen in the urethra. The treatment should be similar to that when they are attacked in other locations.

Obstehrics.

A Case of Spurious Abortion.—Dr. Dixon.—The patient was a multipara (six children, the youngest being 2½ years old). Menstruation was perfectly regular until the end of March, 1897, and she calculated from this time that she was pregnant. As time went on there was a perceptible swelling of the abdomen. On July 8, 1897, I was called on account of hemorrhage having set in, that is, a brownish discharge streaked with blood. The symptoms during the amenorrhea were slight—slight morning sickness and only slight alterations in the appearance of the breasts. As they had been slight also in past pregnancies, they were of little diagnostic value. The uterus on bimanual examination was firm and enlarged, the fundus being felt just above the rim of the pelvis. The ovaries and tubes were apparently normal. The case appeared to be a case of threatened abortion at thirteen or fourteen weeks.

After six days, in which the patient was kept in bed and the uterine muscles kept as quiet as possible, a cast 2½ inches long and I inch broad was passed. Its outer surface was rough, but there was no apparent placental site or any chorionic structure. On examination microscopically it was found to be decidual tissue, and so far as I was able to see no tissue of any other character except blood vessels. The patient made an uninterrupted recovery; bleeding ceased on the day following the expulsion of the cast. No pain was experienced during the whole time.

In considering the case, my first idea was of a fertilized ovum which in some way had perished; my second was, whether the fact that the patient was anxious not to be pregnant (which was in reality the case) had anything to do with it.

Case of Rigidity of the Os Uteri Treated by Hot Baths.— Dr. Hislop.—I was called one evening to attend a primipara, aged forty, who had been in labor for thirty hours. I found her in bed, having very severe bearing down pains both in the back and abdomen. I was told that the waters had all drained away in the morning, and that she had been having very severe pains for three hours. On vaginal examination I found the head presenting and the vagina very small. The cervix was hard and

rigid, and the os completely closed, so much so that I was quite unable to pass a sound into the cervical canal. I ordered warm douches and gave chloroform. I unfortunately had no chloral with me, so was unable to try the effect of that drug. chloroform had no effect. The pains became more frequent and more severe, the whole uterus being forced down with each pain, without any dilatation of the cervix. The patient showed signs of rapid exhaustion, and I had almost determined to make lateral incisions into the cervix, when it occurred to me to try the effect of a very hot bath. The patient was kept in the bath for fifteen minutes, the water being kept as hot as she could bear it. The pains ceased, and did not return for three-quarters of an hour. On making a vaginal examination after her return to bed I was delighted to find that I could easily pass two fingers into the canal and further dilate it. The child was delivered with forceps. I had a little difficulty with the perineum, which was extremely rigid, in spite of continued treatment with hot fomentations for two hours.

I venture to forward these notes in the hope that they may be of some use to a practitioner who has the misfortune to attend a primipara of such an advanced age.

When Shall the Umbilical Cord be Cut?—Dr. Wewer, Der Kinderarzt.—If there are dangerous symptoms on the part of the mother or the child (hemorrhages, asphyxia, etc.), the umbilical cord should be immediately severed. However, in a normal birth, the most favorable time to cut the umbilical cord has not as yet been positively determined. We may benefit therefore by a consideration of the opinions of others.

Meyering (Erlangen) concludes after thorough investigation: The time at which the cord is cut exerts a marked influence on the quantity of blood retained by the placenta. In the early division of the cord, it amounts to 184 grams, in the usual time of division 111 grams, and in the late division 88 grams. It follows therefore that the child, if the cord be tied at once, is deprived unnecessarily of 96 grams of blood.

The larger the quantity of blood which the child receives from the placenta, the greater seems to be its growth in the first days of life. To increase the quantity of blood from the placenta to the child, remove it by Crédé's method. Meyering therefore advocates the late cutting of the cord.

Lábor Engel (Klausenburg) investigated this subject and came to the following conclusion: Aspiration during the first inspiration of the child and contraction of the uterus cannot be the causes which draw the blood from the placenta to the child. Therefore the action of the heart remains to be considered. Children who have the unbilical cord tied late, rest more quietly, do not nurse much, and have a redder skin. From weighing the child no conclusion could be arrived at as to the best time to tie the cord. In the cases of children in which the umbilical cord was tied immediately after birth, 17 out of 90, or 18.88 per cent., died during the first eight days, and in those in which the cord was tied late, 7 out of 74, or 9.45 per cent., died. Therefore he advocates the late tying of the cord.

A. Schucking (Halle) holds that the cord may be tied a few minutes after birth, because the physiological action of the loosening of the placenta undoubtedly carries the blood of the latter to the child immediately following birth. This he considers due to the compression of the gradual loosening of the placenta and the first inspiration (aspiration and clearing the way for the circulation in the lungs).

Schiff found an equal number of blood corpuscles immediately after birth in those whose cord was tied early as in those whose cord was tied late. When it was tied late he found an increase in the blood corpuscles after three to four days amounting to one to two millions, while in early ligature a diminution of these were observed. This reserve blood in late ligature, which amounted to seventy to ninety kilograms, produces an engorgement of the blood vessels through which an easier diffusion toward the lymphatic vessels, the tissues, and the excretory channels is produced. Thus also an increased excretion of urine took place in the first few days in these cases. After a number of days the reserve blood-globules became totally disintegrated and equal to the quantity found in the child whose cord was ligated early. Observe that the child with its reserve blood had to pass through an unnecessary process to reach the point which the child who had its cord ligated early had already reached without any difficulty. ' But the reserve blood causes not only an increased secretion of urine, a temporary irritation of the blood and lymphatic vessels of the tissues and of the kidneys, but it may directly cause a diseased condition, "an icterus of high degree."

Fortunately this icterus is not hepatogenous, but caused by the disintegration of the reserve blood corpuscles. Therefore it seems that in the interest both of mother and child, an early ligature of the cord is to be recommended.

Extra-uterine Pregnancy: Delivery per Rectum, Lasting Many Years.—Dr. Sepibus, Rev. méd. de la Suisse Rom., first saw the patient, multipara, aged twenty-eight years, at the beginning of May, 1884. Menstruation had been absent for three months, and from this and other symptoms he diagnosed pregnancy. In July he found by palpation that pregnancy was fairly advanced. At the beginning of September he was called again. On palpation the abdominal tumor had disappeared, and no gravid uterus could be felt. No signs or symptoms of recent miscarriage were present. The temperature was raised, and she was treated on the supposition that the cause was puerperal. The fever lasted during October, November, and December, 1884. After this she was not seen again till November, 1886, when she produced several fetal bones which she had passed per rectum. The diagnosis of extra-uterine pregnancy, which had burst in September, 1884, was then made. She was advised to go into hospital, but refused and had no further treatment. She continued to pass bones at intervals until December 31, 1891. Their passage usually caused pain, and sometimes hemorrhage; most of them were lost, but six fragments of the skull, one iliac bone, two tibiæ, one femur, one olecranon, one radius, and one rib were collected. After the last bone was passed on December 31, the patient recovered her usual health, and she began to menstruate again. On January 3, 1895, there was profuse hemorrhage from the rectum, and among the clots another cranial bone was found. Acute peritonitis followed, and she died on January 4, 1895.

One Hundred Cases of Labor in Hospital Practice.— Dr. Campbell, British Med. Jour.—Hospital cases were liable to have higher temperatures than those confined in private, because the patients were dirtier, more of the cases were difficult or complicated, and pupil nurses and students were allowed to examine them. They suffered less, however, from lacerations and less often needed the forceps, partly on account of their first pregnancies occurring early in life and because they got more time in labor. Temperature before delivery was raised by tedious labor,

by the presence of decomposing fetuses, by the introduction of bougies to induce premature labor, and by pleuritic pain, a rise being noted in oper cent, of the cases. No serious complications followed delivery in these cases. Temperature at delivery averaged 98.8.° It was over 100° in 13 per cent. In eight of these cases there was no obvious cause; in the remaining five it was due to prolonged labor or to the means taken to induce premature labor. Temperature after delivery was over 100° in 48 per cent. Influenza, emotion, delirium tremens, and difficult forceps delivery complicated the cases in which the temperature was highest. Relation of pulse to temperature showed the rise and fall of the pulse to precede that of the temperature, and proved that a falling pulse and a rising temperature indicated that a sudden great drop in temperature would occur within twelve hours. The breasts gave trouble in 10 per cent, of the cases, but influenced the temperature in only 5 per cent. were most influenced on the third and fourth day. Multiparæ suffered more than primiparæ. The forceps were applied in 10 per cent. of the cases. They were used on account of danger to mother and child in protracted labor, danger to child alone in protracted labor, prolapse of cord, and to cardiac disease in mother. Two children were stillborn in the forceps cases. neum was untorn in 81.3 per cent, of primiparæ. Conclusions: Douching was unnecessary after a natural labor. As done by the nurse it was often injurious. In private practice preventing the nurse from making vaginal examinations would do more to diminish puerperal fever than anything else. In operative cases one douche after delivery should be given. The forceps should be less often used than they are. The perineum was best preserved by giving it time by retarding the expulsion of the head and by avoiding the forceps as far as possible.

A Test of Fetal Death.—In case of doubt regarding the death of the fetus, the presence of acetone in the urine is said to be conclusive. A simple test for this purpose is Chautard's solution or fuchsine (5 centigrams of fuchsine to 100 grams of water and decolorized by sulphurous acid).

To make the test, pour into a test-tube containing 15 or 20 cc. of the urine, a few drops of the reagent. If acetone is present, the urine instantly turns to a violet color, the depth of the shade varying with the quantity of acetone present in the urine.

Nervous Diarrhea in Pregnancy.—Dr. Condio, Centralbl. f. Gynäk.—While hyperemesis gravidarum is more frequent in the higher ranks of life, diarrhea, which appears to be related to the former disease, seems commoner among poor pregnant women. Obstetricians note its occurrence in lying-in hospitals in cities where it is hardly ever seen in private practice. Out of 3674 pregnant women in the Turin Maternity, nervous diarrhea was observed in 35. No fewer than 21 of these cases occurred in primiparæ. Temperature has little influence on this affection, but errors of diet are more probably among its causes. Nervous diarrhea begins about the fifth month, and may become formidable; it has been found to continue even in childbed. Nerve tonics are indicated and, as in hyperemesis, premature labor must be induced if the diarrhea persists and the patient becomes seriously debilitated.

Premonitory Symptoms of Puerperal Infection.—Dr. Freér, L'Obstétrique.-The success of intra-uterine treatment for puerperal fever stands in direct ratio to the earliness of intervention. Hence very careful clinical researches have been made in lying-in hospitals in order to detect true prodromata. rigor, local pains, and conspicuous pulse and temperature are known to all, and when combined indicate more or less advanced These symptoms never come on suddenly, though certain milder types of infection now observed may represent sepsis modified by antiseptic agents. These milder types, however. will assuredly develop into deadly septic infection if neglected, Long clinical research demonstrates that even the severest form is preceded for a day or two by distinct elevation of temperature and pulse, and by insomnia. An evening temperature of about 100° in the axilla, with a fall of about a degree in the morning, without a corresponding drop in a somewhat rapid pulse, is a distinctly suspicious symptom. The rise in the pulse often precedes the rise in the temperature; the observer must therefore make sure that acceleration of the heart's action is accounted for even in a patient who seems otherwise convalescent. Reaction after the fatigue of labor, hemorrhage, and emotions all send up the pulse. Insomnia is often observed in the earlier stages of infection, distinct want of sleep without restlessness is usual for a day or two before bad septic symptoms. The lochia may remain free from odor in the premonitory stage of puerperal septicæmia, nor are the discharges always fetid when the disease is established.



Pędialrigs.

Epidemic Diseases.—Dr. Gottstein, Berlin. klin. Wochenschr.—It is not the cause of the disease, but the susceptibility of the species, which decides the form in which a contagious disease is spread. The mortality of a number of European capitals has been graphically grouped together for the study of such epidemics.

Measles presented a characteristic and for all cities an equal curve. At intervals of three to five years the epidemic flares up, and is then extinguished or continues to run a mild course. The combined rise and fall does not embrace more than one to two quarters of the year, and nearly always falls on the second quarter of the calendar, in many cities even on the same quarter of the year.

The mortality curve of scarlet fever shows cycles of ten to fifteen years, the individual heights of the epidemic wave being two to three years, during which the high mortality continues. Epidemics in large cities, as a rule, decrease together.

Diphtheria becomes epidemic only every quarter of a century, the mortality gradually rising and again gradually falling; at the present time we are living in the decreasing period.

The connection of these phenomena is as follows: Statistic collections in Berlin show that of the population subject to these diseases only a certain number are affected and of these ninety-five per cent. contract measles, forty per cent. scarlet fever, and ten per cent. diphtheria. These different proportions of predisposed persons make the law of epidemics, because through the general susceptibility for measles those who are susceptible will have had them early, and therefore the mortality curve will quickly rise. In a short time it again declines on account of the absence of material, and will remain down until, after a few years, another generation again offers a large amount of material for new cases.

On Diseases of the Spinal Cord in Whooping Cough.—Dr. Bernhardt, Centralbl. für Innere Medicin.—Among the relatively frequent sequelæ of whooping cough certain cerebral disturbances stand at the head, such as hemiplegia of mental diseases and affections of the sensory and cerebral nerves. Rarely, how-

ever, do we meet with spinal cord affections; only two such cases have been observed by Moebins, one an ascending paralysis of Landry, and the other an acute poliomyelitis. The following case is therefore reported: A five-year-old child, suffering with whooping cough, was attacked suddenly, during a cough paroxysm without fever or sensory disturbances, by a paraplegia of the legs. An examination four weeks later disclosed a spastic paraplegia of the legs, increased tendon reflexes, slight sensory disturbances in the paralyzed limbs, and some bladder trouble. The paralysis gradually disappeared under treatment, but the cure was delayed by an attack of double parotitis. At the present time the child is perfectly well, except a slight weakness of the right leg. As regards the diagnosis, we have to deal with an affection of the spinal column, in or about the cord, and most likely with a hematorachis. A hematomyelia may be excluded from the absence of grave bladder and rectal symptoms, defects of sensory functions, and loss of tendon reflex. Hemorrhages under the skin and mucous membranes are common occurrences in whooping cough; but hemorrhage in the spinal column from paroxysms of coughing is a less probable cause than toxic lesions of the vessel, which is frequently observed in infectious diseases. This case was similar to one observed by Turmet, in which there was a paresis of the legs in a little girl suffering from gastric fever. This began to improve, when it grew worse through an intercurrent attack of whooping cough. The difficulties of diagnosis in children are very great as shown in a case of Henoch, which presented typical symptoms of meningitis, although at the autopsy not the slightest sign of a cerebral affection could be discovered.

A Case of Recurrent Smallpox, or Varicella and Variola.—Dr. Stadelmann, Deutsche med. Wochenschr., reports the case of a girl twelve years of age who was taken ill with a red papular eruption over the whole body, accompanied by febrile symptoms; soon vesicles and pustules were developed. The diagnosis was varioloid, and the child was put with others having this malady. Five days after the cessation of febrile symptoms the child was again taken ill with high fever; three days following another papular exanthem developed. Typical smallpox pustules made their appearance, and the child died in collapse on the tenth day.

As regards the question of the nature of the first disease, the author, in view of the long continued fever, the typical pustular eruption, and the gravity of the general condition, holds to the diagnosis of varioloid, although he admits that we have no positive differential diagnostic sign to distinguish it from varicella. If this be true, we have here to deal with a genuine case of relapsing smallpox, a very rare thing. This is of still more interest for the reason that the relapse was much more severe than the primary illness. We must therefore admit an increase of virulence in the micro-organisms of variola in the human body, which is difficult to reconcile with the experiences gained, as to the decrease of susceptibility of the human body, by the inoculation of small quantities of weakened smallpox virus.

Chores.—Dr. Kraft-Ebing, Allgem. Wien. mediz. Ztg.—The occurrence of chorea is much more frequent in the female than in the male, the proportion being about three to one. It is noteworthy to mention that particularly in the female line, a hereditary predisposition to this disease is met with, so that a history of this disease can frequently be traced back in a family to the grandmother, the mother, and the female issue of the latter. From this hereditary disposition the frequent recurrence of the disease might possibly be explained. It would, however, be a great mistake to take a hereditary predisposition always for granted. An acquired predisposition through the diseases of infancy, and especially through rachitis may be brought about. The same has frequently been observed in other diseases, and symptoms of rachitis (especially of the skull) are often found. The existing causes of an attack of chorea, in those predisposed to it, may be divided into bodily and psychic. Bodily causes may be shortly defined as the influences of debilitating and especially of febrile diseases, combined with pain or disturbance of the general nutrition and of sleep. Acute rheumatism has particularly drawn the attention of doctors (especially of the English physicians) to the frequency with which it is followed by chorea. There is no doubt about this observation. The reason attention was drawn to it in England is that acute articular rheumatism is a frequent disease in that country. Endocarditis must be mentioned in the ætiology of chorea as a link between rheumatic affections and the latter, being so frequently a complication of acute infectious articular rheumatism. Experience teaches

that this endocarditis is not absolutely essential to the occurrence of chorea; there are plenty of cases in which chorea makes its appearance in the absence of an endocarditis.

As regards the psychic causes which may produce chorea in the individual predisposed to it, various affections may be mentioned, but fright is the one which is most frequently followed by an attack of chorea. To discuss the symptomatology of this complaint, and to answer the question, What are the characteristic signs of chorea? we meet with some difficulties. At the outset chorea is essentially a motor neurosis, accompanied by spasmodic symptoms of a most peculiar kind. They do not occur in the form of coarse spasms of the flexors and extensors, as we see them, for example, in epilepsy, but present more or less co-ordinated spasmodic movements. Thus they are frequently taken for voluntary motor actions, to the great detriment of these patients, whose gradually developing affection, during the first few days, or even during the first weeks, is looked upon as the antics of a naughty child. These spasmodic symptoms may be of two kinds; they either appear spontaneously or are complicated with other voluntary movements. The spontaneous spasms have the appearance of the seemingly natural movements of pulling, moving off, turning around, and gesticulating; the spasmodic symptoms accompanying voluntary movements may be at once designated as ataxic. For this reason the extremities lose their usefulness and the patient sometimes becomes altogether helpless. In regard to the spontaneous spasmodic movements, it may be said that they are absolutely independent of the will, and are very annoying to the patient. They must originate, therefore, in some internal conditions or irritation. The patient has no knowledge of the reason for the movements. Some ganglia cells must exist in the central organ which are in such a condition of increased excitability that psychic irritations in the form of unknown associations or organic irritation suffice to bring on such movements. As regards the co-ordinated spasmodic symptoms which accompany the voluntary movements, these are not to be explained otherwise than by assuming that the law of isolated conduction is being violated. This brings us back to the theory that an abnormal condition of irradiation is present in the tissue of the nervous system, namely, a diminution of the power of resistance of the tissue.

If, after what has been said, we now inquire from what point we necessarily must imagine the chorea to emanate, we will probably repudiate the original view, which assumes the seat of the disease to be situated partly in the muscles, partly in the peripheral nerves, and partly in the spinal cord. Chorea, as we know, is a disease which occurs semilateral; it may be said to be hemiplegic. It is a disease which is regularly accompanied by psychic symptoms, a disease in which the motor symptoms during sleep are held in abeyance. All these symptoms point to the brain and especially to the motor areas of the cortex as the seat of the choreic movements. This supposition is strengthened by the absence of any location in the central nervous system from which, by any kind of irritation, such complicated movements could be produced, excepting the cortex of the brain.

Chorea generally appears in the form of a hemichorea; it may, however, also involve the other side, but this half of the body will then always be the less affected side.

The diagnosis of chorea will not be difficult, if it be borne in mind that we have to deal with a disease whose expression is essentially unilateral, involving the muscles of the face and tongue in which co-ordinated spasmodic movements are present, which depart essentially from the gross picture of a simple spasm of the flexor and extensor muscles. The age also is to be taken into account, and the fact that during sleep the spasmodic movements are abolished. As regards the disturbance of the voluntary movements, it may be mentioned that the choreic movements are able to overcome the voluntary movements. This distinguishes chorea at once from the intentional tremor of multiple sclerosis and of ataxia in certain diseases of the spinal cord.

A moderately severe attack of chorea persists two to three months. Some rare cases are met with in which chorea exists many months, and even more than a year.

The prognosis of chorea is usually favorable. In the typical forms occurring in childhood and youth, we are justified in promising a cure in most cases. If patients suffering with chorea succumb, it is probably always due to some complication, of which endocarditis in conjunction with articular rheumatism and the occurrence of embolus are the most prominent.

From a therapeutic point of view a dietetic treatment may possibly be all-sufficient to bring about a cure. Rest of the body

and the mind is important. These children must not go to school and parents should not treat them harshly. They should avoid excitement of any kind. A meat diet should be forbidden. A milk diet should be ordered, and as much fresh air as possible.

Infantile Convulsions.—Dr. Sanger, Maryland Med. Jour.—
1. Convulsions are most frequent under two years. There are two periods of frequency—under one month and between six months and two years.

- 2. The nature of the nerve reaction resulting in a convulsion is not understood, but it is probable that instability of nervous tissues at this period of life favors this reaction.
- 3. Convulsions are frequently observed in adult life, and result from auto-intoxications and other causes.
- 4. Convultant substances may be introduced from without or generated within the economy; (a) Substances useful to the economy, if they accumulate, become harmful—for instance, water, carbonic acid, mineral substances, the salt of biliary acids, soluble ferments, toxins not ferments in saliva, alkaloids of secretion in urine; (b) infectious agents may elaborate toxins; (c) organisms constantly present in the economy under certain circumstances may become infectious agents.
- 5. The instability of all the organs and tissues of the infant economy makes auto-intoxication common.
- 6. Convulsions occurring in rachitis and diseases associated with great nutritional disorders; all forms of gastro-intestinal disorders; the acute infectious fevers—are most readily explained on the ground of auto-intoxication.
- 7. Convulsions resulting from marked disturbances in the respiratory and circulatory systems, as, for instance, asphyxia and hemorrhage, are in all probability toxic.

The reflex origin of convulsions is probably not common. It should, however, be noted that when the so-called convulsive habit is established reflex disturbances may bring on a spasm.

Chorea.—Dr. Marfan, Edinburgh Med. Jour., in 76 cases observed by him during four years, found that 49 had a hereditary history of neurophatic origin, while 11 came of alcoholic parents. The immediate history of these cases pointed to chorea as almost invariably a secondary disease following some other affection. Foremost among these primary affections was acute Jaticular rheumatism, which accounted for about half the

cases. In 43 cases no rheumatic origin could be detected, but in 38 the chorea had been almost immediately preceded by specific febrile diseases, tuberculosis, local suppurations, etc.; in 3 instances by undetermined diseases with endocarditis and pericarditis. In 19 cases the neurosis appeared to be primary. He believes chorea to be a neurosis produced by various toxins or micro-organisms, but not necessarily an invariable consequence of some primary or secondary infection by pyrogenic organisms. Chorea is a neurosis like hysteria, but not a hysterical disease. Careful distinction must be made between two groups of cardiac disease associated with chorea; (1) Ephemeral disturbances not disturbed by any lesion; (2) endocarditis or pericarditis. ephemeral cardiac disturbances are due to the fact that the heart takes part in the choreic agitation. There may be hyperkinesis, arythmia, and irregularity or inequality of the heart beat. The murmurs can be distinguished, as their position of maximum intensity is at the left margin of the heart instead of at the apex; they are mainly meso-cystolic, vary with respiration and bodily position, and also vary from day to day as regards character, seat, and intensity. Such phenomena are due to true chorea of the heart. True cardiac lesions were found in only 14 out of 76 cases. It is to be remembered that all diseases that apart from rheumatism commonly precede chorea are apt to give rise to endocarditis and pericarditis. Symtomatic hemichorea is a separate entity, which must be carefully distinguished from this variety. The three great remedies are rest and antipyrine or arsenic.

Lemon Juice as a Preventive of the Gonorrheal Ophthalmia of the Newborn.—Dr. Szawelski (Gazeta Lekarska)—saw during his stay at Professor Pinard's clinic in Paris, the application of lemon juice in gonorrheal ophthalmia with remarkable results.

Several drops of lemon juice are put in the conjunctival sac. It is entirely harmless and is at hand in every household. He reports a striking case with good results.

Electrical Treatment of Infantile Paralysis.—Dr. Larat, Brit. Med. Jour.—No matter how grave the case may be in appearance, electricity must be employed, and that as soon as the diagnosis is

Faradization is not only useless, but positively harmful, for every

time a muscle is in process of atrophy, and which does not respond to the current, is faradized, the tendency to atrophy is increased. It is, therefore, the continued current which should be used, and the following is the method recommended by the author, which has the advantage of being quite painless—a point of great importance in children affected with any nerve lesion: A large disk of tin, the size of the palm of the hand, is covered with chamois leather. This, which should be moistened with tepid water (not salt solution), is placed over the cervico-dorsal region in the case of an upper-limb paralysis, or over the dorsolumbar region when a lower limb is affected. This disk forms the positive pole of the battery. The negative pole consists of a small disk placed in a basin of tepid water, in which the extremity of the affected limb is emerged, hand or foot, as the case may be, and the ankle or wrist must be covered by water. A current of from 8 to 10 milliamperes intensity is passed for about ten minutes. With so large a surface of application the density of current at any particular point is very slight, and the pain nil. After ten minutes the current is interrupted a few times, and it is also advisable when interrupting to reverse the current. In this way these interruptions should not exceed the number of one hundred, and should be made slowly. Later on, when the disease is subsiding, the number of interruptions may be increased and the interval between them shortened. The author points out the only too common fallacy of doing too much in the early history of the case. This treatment must be carried out with great patience, and no decided result must be expected for a long time. The slightest infantile paralysis will require a year's treatment, a bad case several years, but the earlier the treatment is begun the better, and electrical intervention in the very beginning, especially during the febrile period, is of the very greatest importance. The author does not mean it to be supposed that certain cornual cells which bear the full brunt of the disease will subsequently recover, but he is firmly of opinion that the disease is a selective one; that is to say, that side by side are cells severely affected or disorganized, and others only slightly so. These latter may become affected or escape, and this result will depend on electric application. Hence the importance of early treatment.

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VOL. XX.

DIAGNOSIS OF PELVIC DISEASES IN WOMEN.*

By M. P. HUNT, M. D.

IN diagnosing diseases of the pelvic region a large array of instruments is not necessary. The truth of the matter is that the best instruments for this purpose are God-given; they are the fingers, with the sense of touch intact and educated.

A Sims speculum, with an assistant to hold it, dressing forceps, sounds and tenaculæ, are all useful in their way to confirm a diagnosis already made by the digital and bimanual methods, and for their *moral* effect on the patient; but are really of little use in actual diagnosis.

Before the fingers can be useful for diagnostic purposes they must be educated. They must be taught "geography" and "topography" so that they can distinguish, by the lay of the land, whether or not a storm has recently passed over that section. In other words, they must be taught how to differentiate between the normal and the abnormal; between the physiological and the pathological conditions in this region.

^{*} Read before the Homeopathic Medical Society of Ohio, May 10, 1898.

Unfortunately for many a woman, experience is the only teacher; but at the same time "experience" is a good teacher and well qualified.

Froude says, "Experience teaches slowly and at the cost of mistakes." No one knows this better than the doctor. Another writer says:

"Experience, joined with common sense, To mortals is a providence."

If the fingers, then, only follow the instructions given by their teacher, they will soon be able to surprise the owner by their readiness in diagnosing pelvic troubles.

In order that they may have every advantage possible, with no good excuse for mistakes, I would advise that a table or chair be used *always* in making an examination. Oftentimes an examination must be made at the patient's home; especially is this true in the country, where people are not educated up to the point of going to the physician's office for this class of work.

A kitchen table, a dining table, anything that has a straight, even surface and is strong enough to hear the patient, may be used.

An examination should never be made on the bed if the patient can possibly be moved to a firmer surface, for the easy springs and mattresses tend to upset all ideas of the "geography" of the parts to be examined and will mislead the best of us.

The most natural position for the patient is the dorsal, with the legs flexed. This position of the patient is easier for the examiner also, for he can better keep the "geography" of the parts in mind, and by using the bimanual method every part of the pelvic region can be explored. If anything abnormal is found, a change to other positions may be necessary.

That we may have a practical test of the subject as presented, let me take a hypothetical case—say of chronic metritis and endometritis. I take the two because they

usually travel together; and, together or separately, they cover a multitude of ills.

With the patient in the position already outlined, the index finger is passed up to the landmark—the cervix. If the fundus is tipped forward in this case, in order to reach and outline the cervix the finger must go well back and up. The cervix will be found large and indurated; if the patient has borne children there will very likely be one or more breaks in the continuity, running out from the os; these are lacerations—unilateral, bilateral, or stellate.

Around the os there is erosion covering a surface more or less large; the Nabothian glands stand out prominently. The finger, passing along the anterior vaginal wall will feel the body of the uterus enlarged and tender to the touch; the anterior wall, instead of having a slight sulcus at the juncture of the cervix with the body, as in health, will be abnormally straight and the fundus is pressing well down on the bladder, causing those distressing bladder symptoms which usually accompany this condition of affairs. The whole organ is probably movable, but making an attempt to move it by pressure against the anterior wall causes pain—not so much from the movement as from the pressure required to bring this about.

Now, how do we know these objective symptoms are all present when we have not seen them? Can we believe what the fingers tell us? We know the uterus in this case is tipped forward because the finger reaches back and up to the landmark—the cervix; we know the cervix is enlarged by comparison, and that it is indurated by the hard, unnatural feel; we know it is lacerated because we can feel the breaks running out from the os; and that there is erosion because of the peculiar velvety feel, which is not like that of the healthy mucous membrane; we know the Nabothian glands are enlarged because they can be felt. We know the body of the organ is enlarged by comparison, and we know it is tender to the touch and on moving because the patient makes it manifest, either by word or change of countenance; we know this is a case of chronic

metritis because the enlargement extends through and beyond the sulcus, completely obliterating it; and we also know there is endometritis, because it would be utterly impossible to have so extensive an inflammation of the uterus without involving the lining membrane also.

We are back now to the starting point. The diagnosis is made. Are we satisfied? Could we do any better with intruments? Let us try. The patient is placed in Sims' position; an assistant retracts the posterior vaginal wall. Then we have a view of the anterior lip of the cervix. With a tenaculum we draw the cervix downward and forward; this causes some pain because the whole organ is moved, but it is necessary, for how can we determine the cause of this woman's trouble without seeing the condition? And this we can only do by using more or less force.

We now have the cervix in view and can see that it is enlarged, and from the purplish color we conclude it is indurated; we touch around the border with the sound, find it hard and unyielding, which means induration according to the books. Circumscribing the os is a fiery-red condition, which follows along the borders of a rent or groove through the mucous and muscular coats—there may be one or more of these breaks in the continuity. This condition, we have been taught, is called erosion; and the breaks are ocular proof that the cervix has been lacerated. Little elevations like bird-shot, under the mucous membrane, yellowish in color or opaque, cover the surface of the eroded portion; these are Nabothian glands which are enlarged; prick one with a sharp pointed instrument, and it will discharge a thick, tenacious, transparent fluid-like the white of an egg. Further, in order that we may determine the position, depth of the uterus, and general condition of the endometrium, we must "pass the sound." We find, in doing this, that the instrument must be curved quite sharply forward at the tip in order to pass it into the uterine cavity, and that, when it is inserted, the handle points downward and backward, showing conclusively that this particular case is one in which the body of the uterus

lies forward. Then too, just as the sound passes the internal os, or rather touches it, the patient will shrink with pain. The lining membrane has a peculiar cushiony feel, and wherever the sound touches, in its exploration of the cavity, there will be pain, and blood will follow its withdrawal. This, the books and professors teach, indicates endometritis. After this procedure we say this patient has chronic metritis with the accompanying endometritis; and that the uterus is anteverted. The examination was painful to the patient, and she stands a very good chance of having a subsequent attack of pelvic peritonitis or celulitis.

I ask you, "Was the game worth the candle"? Was it necessary to subject this woman to the pain and danger of instruments that we might diagnose this trouble? Did not the fingers tell us as much, or more? Can you think of any disease of the pelvic region where instruments are, primarily, necessary for diagnostic purposes? I claim not. And I claim further that the passage of the sound, or any instrument, into the uterine cavity is a surgical procedure, and should be accompanied by all the precautions usually taken in any operation upon that organ.

PUERPERAL HEMORRHAGE—CURED BY CURETTE

BY PORTER S. KINNE, M. D.

THERE is to the practitioner of obstetrics, perhaps, the whole list of accidents that are liable to occur the lying-in woman, nothing more appalling than the terrible cases of flooding after labor, in which, as is indicated by the death-like pallor, the woman's life is quietly ebbin away: the cold, hurried breath; the clammy, waxen sking the intermittent and sometimes absent pulse; and the rapidly recurring fits of fainting, from which she recover only long enough to make a few gasps, utter a short, feeling hardly audible sentence, and again lapses into a swoothat, not unfrequently, alas! closes the scene of her earth career.

At this picture we will no longer gaze, but turn of thoughts for a few moments to a case of secondary pue peral hemorrhage.

Mrs. V., primipara, aged twenty-four, was confine January 9, 1898. Her general health during pregnancy we all a physician could desire; every organ normal, and performing its function with regularity; labor was not more than twelve hours' duration; and the several stages passed safely. At 4 A. M. January 9 (Sunday) she was delivered without instruments, ergot, or chloroform, of a lively be weighing eight pounds.

The placenta was carefully examined and found "a there." There were no unusual symptoms following; the lochia were normal, milk appearing on the third day, without any increase of temperature; bowels evacuated of fourth day, without aid.

January 16, one week after birth, patient felt "perfectivell," desired to sit up. She had not left recumbent postion.

January 17 (ninth day), during the afternoon, she wa taken, without any warning, with a profuse discharge of bright blood. I hastily responded to the call. Examination revealed nothing but the hemorrhage.

The symptoms present were hemorrhage, pallor, and faintness. Gave china and ipecac.—elevated hips. Within an hour, discharge less. Continued treatment.

At the end of twenty-four hours patient seemed to be improving, still the flow was constant and same in character, but less in quantity.

Tuesday night the condition was worse; temperature rose to 100°, pulse 120. Wednesday, temperature 102°, pulse 120; flow continuous and more profuse; no odor, no abdominal tenderness, pain or tympanitis.

Gave an intra-uterine douche of hot water. Fluid extract ergot, thirty drops every two hours; no improvement of any symptoms.

Thursday, temperature 103\{\frac{1}{2}\}^0, pulse 130, discharge same in quantity, darker, and offensive. Gave intra-uterine douche: one dram creoline to one quart of water, temperature of which was 110°.

As no satisfactory effects of this treatment resulted, and the efficacy of medicine failing, I at once sought surgical aid.

Patient was etherized, and uterine walls thoroughly and carefully curetted. The result of this operation was the removal of débris to an amount equal to two tablespoonfuls—what seemed to be placental tissue and a small amount of the endrometrium.

Within twelve hours after curettage the temperature fell to 101°, and daily lessened, hemorrhage ceasing, and on the fifth day after temperature was normal; and only the discharge subsequent to curettage followed.

Of course the patient was very anæmic, lips and ears colorless, but sat up on the twelfth day.

During the hemorrhage and convalescence she was well nourished with milk and whisky, also Trophonine—half an ounce every two hours—which I consider superior to any concentrated food. She made a most satisfactory recovery.

During the past twenty-six years I have been present at nearly twelve hundred births, and this is the first case of secondary hemorrhage I have met. It being exceptional and rare, I report the case.

Secondary puerperal hemorrhage is set down as coming on at any time from one to forty or more days after delivery, and as being fatal in rather a large number of cases.

What was the cause? Not ergot, for it was not given. There was no subinvolution. The placental mass was entirely expelled, as careful examination demonstrated. There were no hourglass contractions, by which anything could be retained.

It is, of course, very possible that some portion of the secundines were retained. My own opinion is that the patient was the unfortunate possessor of a placenta succenturia, that anomaly of form which deserves special mention, in which supplementary placenta exists; the accessory developments being due to the persistence of isolated villous groups, which form vascular connections with the decidua vera. They are of consequence, inasmuch as they are liable to be left in utero, and give rise to persistent post-partum hemorrhage.

Hohl says, "they always form at exactly the junction of the anterior and posterior uterine walls, and the portions of placenta on each side of the lines become separate."

Such is the clinical history of a case that for some days caused me much anxiety, and I hope may be useful in its lesson.

PREVENTION OF PELVIC DISEASES IN WOMEN.

By J. C. FAHNESTOCK, M. D.

IN the November, 1897, HOMEOPATHIC JOURNAL OF OBSTETRICS, GYNECOLOGY, AND PEDOLOGY there appeared an article on "The Prevention of Female Pelvic Disease"; and, as this is a field of labor in which I am greatly interested, any light thrown on its dark places is greatly appreciated. I thank the writer for his able paper; at the same time I shall be obliged to take a few exceptions, not in the way of creating a controversy, but merely to relate a few of my experiences.

The doctor makes the suggestion to all gynecologists who may read his article that they turn over the leaves of their memory carefully, and see if they can recollect a single case of conception in a patient whose uterus had been thoroughly curetted.

The doctor wisely remarks that "curetting is quite frequently necessary," but sounds the alarm against its abuse and indiscriminate use, and in that every true gynecologist will concur.

In the beginning of his article this statement is made, "that there was a time when remedies were given indiscriminately for weeks before confinement by him; and that without indication; but he learned very soon that the only true method was to give the indicated remedy."

Everyone will admit that this is the only true way of prescribing remedies for any abnormal condition. If the patient is perfectly healthy he admits that no medicine should be given. In these two statements every true follower of Hahnemann must agree.

But following these definite statements he immediately runs in his former routine and commends the method of giving his prophylactic treatment to every case after the removal of the placenta; a teaspoonful of a solution of cider vinegar.

There is no doubt this has an effect in contracting the

uterus, but I cannot in any way see why this indiscriminate use of vinegar should be recommended when not indicated. Professor Burdick years ago gave his pupils the clear indications for vinegar in uterine hemorrhage, but advised against its use unless indicated. The professor was a teacher of the true Hahnemann kind; his instructions I have always found to be the best, and I honor him yet, though dead.

Place the palm of your left hand over the fundus and produce gentle kneading while the placenta is being expelled, then grasp the uterus quite firmly. By so doing it is thoroughly contracted. After which keep the hand quite firmly over it for some little time. In this way the uterus is so firmly contracted that it rarely relaxes, thus preventing an accumulation of blood, and so avoiding the necessary contracting in order to expel the source of irritation; viz., the clot of blood.

If this procedure is closely followed, there will be no indication for a remedy and none required. Still further on we find the indicated remedy—or an advertisement for a phosphates preparation; I cannot exactly make out which it is—to prevent taking cold. I wonder if this is clearly indicated, or given regardless of any indication.

Now in reference to curetting the uterus and destroying the minute villi of the endometrium, "thus preventing pregnancy," I cannot agree with the author. Experience to the contrary has fully demonstrated to me that this is not the case.

In 1895 I had a case which I thoroughly curretted the second time for an obstinate hemorrhage and leucorrhoea, which I could not control by my best efforts in selecting a remedy. I gave each that was seemingly indicated a fair trial, and I assure you that I am a firm believer in the well-selected remedy. In 1896 this woman died from valvular disease of the heart. I held a post-mortem and found results as expected. I then turned my attention to the abdominal and pelvic organs and to my surprise found 62 gall stones as large as grains of corn; strange to say, she

had not made any complaint about them for twenty years. I then examined the ovaries, which were atrophied. Then I laid open the uterus; the endometrium looked healthy. and no marks could be seen from the curetting.

If tissues are reproduced in other parts of the body by cell proliferation, why not in the uterus? I very recently removed the fluid from a hydrocele of the spermatic cord. I saved the fluid taken from the right side, and to my surprise found the fluid neutral in reaction and teeming with spermatozoa. I made a careful study of the action of the spermatozoa for several hours in the afternoon, and again in the evening. The spermatozoa would have a snake-like motion, and seemed to turn a regular somersault and move at such a rapid rate that they soon moved across the field. Others had an angular and much more rapid motion. Some were seen to enter the spermatic cells which were in the This fluid was kept at about 70°. The next morning I again studied their action, when they seemed to be regular gymnasts, so rapid were their movements. At noon other specimens were examined with like results. In the afternoon and at o P. M. the movements of some were suspended, but still quite a number were very active. The following morning the fluid had an alkaline reaction and no motile spermatozoa could be found, but all were coiled up.

From these observations you can readily see that the spermatozoa can travel quite a distance in twenty-four or forty-eight hours in a suitable fluid and temperature, without any villi. Furthermore the villi would only hinder the progress, for their action is not upward or inward but outward. Now, coming directly to the doctor's inquiry, I will relate a few of a number of cases, which I hope will be sufficient.

Mrs. A., a lady who had been given up to die from consumption by two of our prominent physicians. She had a very severe cough (expectorating a large quantity of muco-pus every day), diarrhea, night sweats, and hemorrhoids of the worst kind, eczema of the face, neck, and ears;

and goiter. A general run-down condition and no appetite. Anyone would have given an unfavorable prognosis. I informed her husband that I would operate, give the indicated remedies and wait for developments, which in my judgment would be rapid one way or the other.

I performed the American operation, throughly curretted the uterus, and removed all jagged parts of the vagina. To my great surprise she was better the next morning—the improvement continued, and she regained perfect health. The enlarged neck and eczema disappeared. In 1893 I confined the woman; results, a twelve-pound girl. This lady is perfectly well to-day.

CASE II. Mrs. H. I removed a small polypus June 30, 1893; after which she had high fever. The third day I curetted the uterus, after which there was rapid recovery. On July 25, 1896, I was chairman of the receiving committee for this lady, and the result was a 12½-pound boy.

CASE III. Mrs. G. On October 29, 1893, I performed trachelorraphy and perineorrhaphy, also thoroughly curetted the uterus. She regained her health rapidly, and, as she said, "notwithstanding all precautions," she became pregnant and I confined her February 18, 1896, of a girl weighing two pounds more than her first baby.

CASE IV. Mrs. H. I removed a mole from this lady in 1895, after which I thoroughly curetted, and in eleven months from date I safely delivered a large, healthy boy.

I will only report one more case, and I think it will be convincing proof that curettement does not prevent conception.

Mrs. W. had been treated for some years for, as she stated, a general run-down condition and an aggravated case of piles. July 12, 1893, I performed the American

operation and thoroughly curetted the uterus.

She also had profuse leucorrhea, thought to be due to a severe case of ovaritis. After the operation she immediately improved and enjoyed quite good health until the beginning of 1897, when she began to suffer from the ovaries and also from a profuse leucorrhea. Remedies were faithfully tried, but seemed to have no effect. April 11, 1897, I again curetted in a most thorough manner, the result being most gratifying—with all the rest, she is now pregnant seven months.

THERAPEUTIC LIMITS IN GYNECOLOGY.

By Theo. Y. Kinne, M. D.

THIS is pre-eminently the practical age of the world. Of theories there are many; but they must demonstrate their truth in practice or else be rejected. The inventor's model may be perfect, yet utterly fail to produce the desired result. Those terrible engines of war lying just off our coast combine within themselves the crystallized thoughts of many minds; but men wait with bated breath and expectant gaze to learn what shall be the outcome of all their efforts.

Investigators are peering into every nook and corner of the visible worlds in order to discover something new or hitherto untried which may be utilized for human necessities or desires. Intangible forces are arrested in their course and harnessed to the car of progress, which ofttimes is retarded rather than accelerated by their employment.

Amidst all this there are eternal verities against which the shafts of speculation harmlessly hurtle, and the fusillade of ridicule impotently rebounds. One of these truths is the divinely ordained law of cure for all the ills to which the flesh is heir, and when thoroughly understood, it will usher in the physical millennium. Standing before the Therapeutic Statute, we are assailed by doubts regarding its applicability, questions about its universality, and charges against its efficiency.

The iconoclasm of the present century is exceeded only by its temerity; in fact, the Tower of Babel is inverted. Witness the growing tendency to isolate the various organs of the body, and treat each as an entity without due regard for the correlation. A boy, wishing a watch, was asked what he would do with it. He replied, "Take out a part, and see how it would go." If the ancient adage is true, "When God wanted to make a woman, He took a womb, and built her up around it," then I ask, if that organ be removed, what becomes of the surroundings?

The field of medical science is so vast that, like China, it is parceled out and each power takes a piece. Under existing circumstances, it is inevitable that there should be two extremes—therapeutists pure, with remedies and adjuvants all potent, and chirurgeons who hold the knife sufficient: while between the two lies the golden mean where both clasp hands and each regards the other as the complement.

In no department is this more apparent than in gynecology. That therapy has its limits most will admit; that its bounds are trenched upon, few will deny. Intellectual assent is not heartfelt appreciation, any more than deism is necessarily religion. It has been said quaintly, if not aptly, —"Give a man a speculum and he'll see that for which he looks." This may or may not be true, according to the individual. Conservative surgery is a boon to man and especially to womankind; but I believe the concurrent judgment of physician and surgeon should be prerequisite to heroic treatment.

Through human frailty prejudice can never be entirely eliminated, and the man who sees in every case a chance for operation at least should be restrained, if not distrusted. I confess to a certain unpleasant sensation when I hear eminent surgeons say they care little or nothing for remedial treatment. No doubt, many cases come to the operative stage through faulty medication or cursory treatment, but, with the advance of homeopathy, these will lessen in number.

I know it is better to go through life halt or maimed than to be lost, but give the poor patient a chance before you ablate, enucleate, or emasculate, whichever it may be. Manual work is more patent than mental; deftness more admired than delving; the reportorial more consulted than the repertory; but it is through the latter that homeopathy has made its way, and blazed the path for the army of occupation.

I do not decry the immense progress made in surgical and other departments, but I do plead for a more earnest

study of therapeutics. Appendicitis is not the only epidemic at the present time. We are builders in our generation, but we must remember that the stone we are rejecting must be the head of the corner, or our distinctive edifice will tumble about our heads.

Of the diseases peculiar to the generative organs many are preventible, some are curable with remedies, a few are without the pale of therapeutics. Prompt medication, strict hygiene, early recognition of sympathetic influences often will prevent lifelong regret. A gynecologist of national reputation once admitted to me that if physicians were more studious his work would be less; and if he had depended more on remedies the permanent results would have been better; although I knew his record was more than the average.

I know a surgeon (not homeopathic), who in one day operated successfully (?) upon three patients—none of them with malignant disease—and they promptly died within forty-eight hours. Nothing can restore them to their families and friends, and certainly homeopathic therapeutics could have done no worse.

How often are we entertained by the narration of a brilliant operation, and how seldom by the report of a cure through persistent medication. Is it because there are so many of the former, and few of the latter? I trow not. Rather, may it not be through vacillating prescription; the fact that recovery is in accordance with no violation of Nature's law; or the neglect to promulgate results for the benefit of our brothers.

I fear we do not heed the injunction "to do good and communicate, forget not"; but serene in the consciousness of success, we feel we can afford to wait. Yes; but suffering humanity can't; and its needs cry out for our assistance. The general practitioners, who outnumber the others ten to one, find their credit and their cash grow beautifully less, through the awe engendered by their more showy competitors, not coadjutors.

Minor diseases should be arrested and cured before they

become major, and thus preclude the necessity of mutilation. Already has been heard the warning from conservatives against indiscriminate operating—not from knowledge of a better way, but dread of possible consequences. Sooner or later, a reaction will take place in this, as in other fashions, and then will be our opportunity for demonstrating the supreme efficacy of our therapeutic law.

I cannot better enforce what I would impress upon your mind and heart than by quoting the words of our confrère, Conrad Wesselhoeft: "When homeopathic practice shall have become more general; that is, when the immense wealth contained in its Materia Medica shall have been better understood and appreciated, many of the present specialties into which the old school is being dismembered, many of the present specialties will be again united into one of much wider scope."

A SYMPOSIUM UPON OBSTETRICAL PRACTICE.

By Various Authors.

In Manual Extraction How Long Do You Wait Before Introducing Hand, and What Preliminary Preparations?

A clean hand as soon as needed.—Dr. J. D. Jones.

Till pains lessen and lose their effect .- Dr. Mary Branson.

I use the hand as soon as I reach the case, to assist in dilatation; the hand thoroughly anointed with fresh lard.

—Dr. J. T. Thatcher.

As soon as I know it must be done; good soaping and thorough washing of the hand.—Dr. O. S. Wood.

If there is no progress in three hours, I employ instruments; my hands are repeatedly scrubbed with green soap and hot bichloride solution; instruments sterilized by boiling in hot water for half an hour.—Dr. J. M. Smith.

When hand is to be used, thoroughly wash and scrub hands in boiled water, and green, soft soap; then fingernails thoroughly cleansed, then scrub and wash again; use

no antiseptics whatever; no lubricant except soap on hands.

—Dr. E. E. Reininger.

When manual extraction becomes necessary, usually wait for one-half hour to an hour; the only preparation is to render the hand and arm aseptic.—Dr. W. M. Bailey.

As soon as the head ceases to advance; wash hands in boiled water.—Dr. Kate L. Hickox.

Usually an hour, unless hemorrhage is severe; always with antiseptic precautions; washing hands in bichloride solution, 1-2000.—Dr. R. D. Wilson.

As soon as malposition is noticed; simple cleanliness, and use of sweet oil, or lard.—Dr. H. P. Holmes.

If there is no particular reason, wait until dilatation is sufficient not to endanger the os.—Dr. S. Wilson.

So long as nature seems to make regular progress; absolute cleanliness; asepsis—not antisepsis; lubrication.—Dr. O. A. Watson.

That depends. Wait for complete dilatation, if I can. Otherwise I dilate, using aseptic precautions.—Dr. R. N. Foster.

Antiseptic preparations; variable time.—Dr. G. M. Ockford.

So soon as abnormal labor supervenes.—Dr. H. E. Beebe.

Depends entirely upon condition of patient; nature of condition requiring intervention, etc.—Dr. H. C. Aldrich.

Whenever I see that the forces of nature are inadequate.

—Dr. C. T. Canfield.

Do not believe manual extraction often necessary, when proper external means of placental extraction are practiced; I remove placenta immediately.—Dr. W. D. Bayley.

As long as reasonable progress is made, and there is no danger of exhaustion for the mother.—Dr. J. T. Smith.

In a practice of twenty-five years have never had a case requiring manual extraction.—Dr. Chester Smith.

When os is sufficiently patent to reveal possible presentation—immediately; wash well with carbonate of soda and any antiseptic, espcially carbolic-acid solution; turpentine to cleanse the hands, if there is any doubt as to their surgical cleanliness.—Dr. J. K. Culver.

Until the os is dilated.—Dr. E. J. Jones.

Never had to use it .- Dr. W. B. Robinson.

This would require too many modifying clauses.—Dr. G. Forrest Martin.

Hard to answer, as question is not specific enough; in general, the hand is introduced only to turn, or in breech cases to bring down a foot; then I wait until the os is sufficiently dilated to enable the work to be done without too much danger of lacerating.—Dr. A. L. Fisher.

Only until dilatation is completed; careful antiseptic precautions; bichloride wash or creolin.—Dr. Chas. L. Nichols.

If after cervix dilated, and labor pains active, head not descended through superior strait, and in malposition, resort to turning; strict asepsis used, hands and arms bathed in Laborraque's solution, and rinsed in sterilized water.—Dr. W. D. Youngman.

Until the patient shows signs of fatigue, or I see that pains are insufficient.—Dr. F. D. Brown.

Until pains become ineffective; ordinary aseptic precautions.—Dr. W. I. Tyler.

Never have had to employ it.—Dr. F. P. Batchelder.

Only until os uteri is sufficiently dilated; wash hands thoroughly in hot water or peroxide of hydrogen solution, 5 to 10.—Dr. L. Allen.

If no hemorrhage, and patient is doing well, will wait three-quarters to an hour; external massage of uterus, and Créde's method generally sufficient; perfect asepsis.—Dr. J. M. Ward.

If the manipulation required to correct transverse position is meant, I would answer as soon as sufficient dilatation has occurred to admit the hand, and if dilatation is slow, dilate artificially; if for extracting placenta, as soon as it is known that manual extraction is necessary; for adhesions of the placenta and hour-glass contraction I see no use in waiting, but on the other hand believe that the safety of the

patient is greatly increased by promptly removing the secundines.—Dr. C. G. Higbee.

Are forceps used?

To this forty-eight answer Yes; two, No.

Yes—whenever the head gets impacted—the forceps save hours of hard labor and often save the child.—Dr. O. S. Wood.

Yes, when no progress is being made after three hours of ineffective work.—Dr. J. M. Smith.

Never take my forceps with me except where I deem it wise to use frontal traction.—Dr. A. Berghaus.

In all cases where there are ineffectual pains or danger of exhaustion, for a patient can be delivered with forceps without any danger from their use, and with very much less pain; but no physician should attempt the use of forceps unless he can tell the position of the head by the use of his finger, and then change every wrong position; and he should be able to deliver her when lying upon her side or certainly upon her back, well covered up.—Dr. A. W. Cushing.

Not so much for extraction as for correcting defective positions of head, which I find is the usual cause of retarded labor.—Dr. M. D. Youngman.

Always detach forceps before head passes perineum.— Dr. Chester Smith.

In ten per cent. of my cases. I am very often urged to use them when there is no necessity for their employment.— Dr. A. L. Fisher.

In all cases where the patient does not object, if the labor is at all severe.—Dr. A. M. Duffield.

Once, in deformed pelvis.—Dr. W. B. Robinson.

In what per cent. of your cases?

The answers to this query show the widest possible variation; from less than two per cent. up to ninety. Three use them in two per cent. of their cases; six in five per cent.; thirteen in ten per cent.; two in fifteen per cent.; six in twenty per cent.; four in twenty-five per cent.; two

thirty-three per cent.; three in forty per cent.; seven in fifty per cent.; one in sixty per cent.; one in seventy-five to ninety per cent.

What make preferred?

The replies to this query show as great a diversity of opinion as to the percentage of their use. Fourteen prefer Elliott's; seven, Hodges'; six, Comstock's; four, Sanders' four, Wallace's; three, Simpson's; two, Hale's; two, Bur dick's; and one, each, Duncan's, Bedford's, Fitch's, Roher's Tarnier's.

I am now using an Elliott and get along well; have used Comstock, Davis, and Hodges, etc., get along well with any of them.—Dr. Wilson.

Not particular, so long as handles are thin and narrow.— Dr. Geo. M. Ockford.

Have Burdick's; have delivered with them in consultation cases, when other makes had failed to do so.—Dr West.

Any long forceps; I use Elliott's, but have no real preference.—Dr. O. S. Wood.

Have used only Bedford's; think I would like a pocket forceps in some cases.—Dr. J. M. Ward.

Comstock's, with ebony piece attached to the handle, are used; several other makes are probably just as good.—Dr. A. L. Fisher.

Comstock's when long forceps are required. I use them probably because I am accustomed to them; when short forceps are all that are needed, Jones'.—Dr. E. E. Reiniger.

Hodges' Baudelocque long forceps; I do not know as they are in the market now. I bought mine forty years ago and I have never seen better, but I have seen those in the market that are only fit to pick a dead cat from a swill barrel; with them there must be a ruptured perineum often.—Dr. A. M. Cushing.

I use them only in case of long, tedious labors, and not then if I can help it; I prefer to wait for nature.—Dr. J. T. Thatcher.

In the high application I get them on the best I can and draw head well down and remove them, leaving the case to nature for half an hour, unless an emergency exists; in that case reapply to the side of the head, if I can; if not, follow the pelvic curve.—Dr. A. L. Fisher.

What method of delivery is preferred?

As quite a number to whom inquiries were addressed evidently did not understand the question, the answers are comparatively few. Thirteen prefer the woman upon her back; two upon her back or left side; one on left side; one on right side; and one on left genu-pectoral.

On the back; I always try to permit the birth of the head during a pain by holding it back with my hand partially in the vagina and partly in the rectum; when the pains are absent by having the patient bear down and bring into play the abdominal muscles; one can shell out the head, as it were, with the fingers; I have sometimes found the use of lard beneficial in softening the perineum.—Dr. S. H. Knight.

Patient on back, in bed in usual way; that is, as she sleeps in bed in her usual way; if a difficult case, across the bed, buttocks at edge of bed, limbs apart and fixed on edge of bed by an assistant for each limb.—Dr. E. E. Reininger.

Any method aside from dragging the patient to the side of the bed and exposing her to cold air and the gaze of spectators; that is barbarism.—Dr. A. W. Cushing.

Patient on back, across the bed, her feet resting on two chairs, one foot at least; the operator standing between the knees.—Dr. M. D. Youngman.

I am most accustomed to having patient on back, but can sometimes do as well or better with her on side.—Dr. F. P. Batchelder.

On side, on back for forceps.—Dr. J. Kent Sanders.

Patient lying on side immediately before and during delivery.—Dr. J. M. Ward.

Up and down the bed, under cover, and on the back.— Dr. A. Berghaus. When no anæsthetic is used allow patient to assume most comfortable position she can find; when anæsthetized, put her left side, knees drawn up; when forceps are used, patient on back.—Dr. H. C. Aldrich.

With hips brought to edge of the bed, dorsal position, head and shoulders raised a little.—Dr. C. T. Canfield.

What remedies for after-pains?

The replies to this query are as varied as the choice of forceps, and include nearly all the remedies in the materia medica. Arnica was named 24 times; pulsatilla, 14; cimicifuga, 10; belladonna, 9; chamomilla, 9; gelsemium. 8; caulophyllum, 8; secale, 5; nux vomica, 5; bryonia, 4; coffea, 4; colocynthis, 3; xanthoxyllum, 3; cuprum, 2; amyl nit., 2; viburnum op., 2; sepia, 2; aconite and arnica, 2; crocus, cantharis, secale, ustilago, ferr. phos., kali phos., calc. fluor., rhus, sulphur, proto iod., merc., china, kali mur., magn. phos., sabina, verat. vir., codeine, and causticum, each once.

Secale or, if severe, svapnia.—Dr. Berghaus.

Quite a number of remedies have been used successfully. Always prescribe symptomatically, but arnica always after hard labor.—Dr. J. S. Smith.

Only one needs special mention, ustilago, when pain is severe and the flow is at the same time unnaturally profuse.—Dr. A. L. Fisher.

Secale, viburnum op., cimicifuga, chamomilla, arnica, according to indications.—Dr. Geo. M. Ockford.

Seldom need remedies if Créde's method is followed in delivering the placenta.—Dr. C. T. Canfield.

Viburnum op. is my best remedy.—Dr. J. K. Warren.

Arnica, caulophyllum, cimicifuga, or any other remedy that particular symptom may indicate.—Dr. W. M. Bailey.

Chamomilla, arnica, caulophyllum, and belladonna; if uterus is thoroughly kneaded after child is born and good contraction is induced, I have found little trouble with afterpains.—Dr. J. M. Ward.

Try to prevent them by securing firm contraction of

womb after delivery and generally have little trouble; give morphine, opium suppositories, quinine, cuprum arnica, etc.—Dr. M. D. Youngman.

I do not have much complaint about after-pains; I firmly believe the strictly homeopathic medication before labor, three to six months before birth, modifies and prevents much suffering; I give internally arnica, six to ten doses, every hour a dose, which I believe very much modifies all after effects.—Dr. E. E. Reininger.

Arnica, chamomilla; these are the only remedies I have been called upon to use, when macrotin 1x has been used in preparatory treatment.—Dr. L. Allen.

Cimicifuga tincture, in material doses; if that does not relieve I give opium, also in material doses; after-pains may to a large degree be prevented, or at least rendered less severe, by thoroughly emptying the uterine cavity of blood clots and making pressure over the uterus with the hand for a half hour or more.—Dr. C. B. Higbee.

Phenacetin, unless there are very clear indications for the homeopathic remedy.—Dr. Wilson.

Bryonia, most frequently the indicated remedy.—Dr. O. A. Watson.

Not much success with medicine. I am not positive that I ever relieved an after-pain, excepting with svapnia.—Dr. W. D. Bayley.

According to totality, of course.—Dr. A. H. Tompkins.

Remedies not of much account.—Dr. A. M. Duffield.

I had one case, years ago, in which the after-pains were entirely absent from the uterus, but exceedingly severe, persistent, and regular in the "shin bone" (tibia,) for several days until I gave carbo veg., which promptly and permanently relieved.—Dr. R. A. Adams.

In case child is lost, what treatment of the breast?

Pump, until gradually the secretion is lost.—Dr. R. A. Adams.

None except to preserve from chilling.—Dr. A. H. Tompkins.

Limit diet: externally camphor or hamamelis.—Dr. A. M. Duffield.

Tight, well-applied, unbleached muslin bandage, first protecting breast with absorbent cotton.—Dr. W. D. Bayley.

Emptying to the point of softness, with gentle rubbing; never fully empty the breast, only to the point of comfort to the patient.—Dr. O. A. Watson.

Camphorated oil, etc.—Dr. Wilson.

Use the breast pump until the lacteal secretion has become fully established; then dry up the milk gradually.— Dr. C. G. Higbee.

Let it alone as far as possible. If trouble shows itself, apply hot hamamelis cerate.—Dr. L. Allen.

Use breast pump; bry., lac can.; have never had serious trouble with breasts.—Dr. E. E. Reininger.

Believe they need little treatment except cautious withdrawal of milk occasionally, for first few days. They "dry," if left alone; have used camphor, belladonna ointment, etc.—Dr. M. D. Youngman.

Bandaging the breasts tightly, drawing all milk from the breasts before so doing.—Dr. J. M. Ward.

Belladonna internally.—Dr. Mary Branson.

Bandaging and belladonna plaster.—Dr. H. C. Aldrich.

Proper support with bandaging and belladonna 2x internally; always excellent results; have never had to use measures to remove milk from breasts.—Dr. F. P. Batchelder.

Strap the breasts if they are not full of milk, and give pulsatilla high.—Dr. A. W. Cushing.

Compression by bandaging; phytolacca cerate externally; internal remedies as indicated.—Dr. J. M. Smith.

Artificial nursing; just enough to give relief and let the milk dry up gradually; never use camphor externally. I have never lost a child in my own practice yet, but in the many dispensary cases I have seen a number of bad breasts; the general method of treatment has been some local application as phytolacca or belladonna ointment, with support

of the breasts in mild cases; in severe cases nothing succeeds as well as firm, continuous equal pressure; any milk in the breasts should be drawn with a breast pump, and if any pus forms it should be allowed vent by an opening before it has a chance to burrow—Dr. S. H. Knight.

Bandage tightly over large cotton compress, bryonia most often internally; sometimes camphorated oil applied.— Dr. G. F. Martin.

Keep well emptied .- Dr. H. P. Holmes.

Compression; belladonna ointment, if needed.—Dr. G. E. Tyler.

The ordinary forked bandage and entire letting alone.— Dr. C. L. Nichols.

Rub in camphorated oil; draw moderately with breast pump; milk gradually ceases.—Dr. R. N. Foster.

Apply hot alcohol and water until milk flows readily.— Dr. J. F. Smith.

Hot compresses of phytolacca; phytolacca, bryonia, or belladonna internally.—Dr. Hughes.

Rub breasts with camphorated oil or vaselin, and keep milk out with a breast pump.—Dr. W. M. Bayley.

Bandage tightly; if the breast is very painful, use the breast pump just enough to give relief.—Dr. Kate L. Hickox.

Phytolacca internally and externally.—Dr. J. T. Thatcher.
Application of oakum, tightly bandaged.—Dr. A. Berghaus.

Generally apply belladonna breast plaster before milk is secreted, and give ergotine internally.—Dr. Geo. M. Ockford.

Belladonna plasters, covering a fifth or sixth of the breast, are applied as soon as the breasts begin to distend, and are left on until breasts resume former size.—Dr. A. L. Fisher.

Pressure with a four-tail bandage or a towel.—Dr. Warne.
No treatment except to apply bandage the second day.—
Dr. C. T. Canfield.

To resolve cake-breast, what?

The favorite remedy in this condition appears to be phytolacca, twenty-five physicians giving it first place;

bryonia is named seventeen times; belladonna, ten; aconite, two; hepar, merc. iod., merc. sol., verat. vir., calc. iod., calc. carb., and phosphorus once each.

Hot applications and the indicated remedy, bell., bry., phyt.; do not allow nurse to handle the breasts unnecessarily; hot lard, or hot Pond's Extract, sometimes brings about good results.—Dr. C. T. Canfield.

Phytolacca and bryonia very often.—Dr. A. L. Fisher.

Absolute rest of breast with covering of absorbent cotton; or, if inflammation is severe, phosphorus in hot water or sugar of lead solution locally.—Dr. Geo. M. Ockford.

Have not seen a case of caked breast in eighteen years; to prevent it have the breast rubbed with lard or sweet oil; use bryonia or phytolacca internally.—Dr. A. Berghaus.

Hot glycerin applied locally and phytolacca internally.— Dr. J. K. Warren.

Antiseptic dressing; acon., bell., bryonia; empty breast by suction.—Dr. W. D. Foster.

All that has come in my practice could be rubbed away with the hand.—Dr. Kate L. Hickox.

Hot fomentations; phytolacca externally and internally, or any other remedy that special symptoms may indicate.— Dr. W. M. Bailey.

Aconite, belladonna, or bryonia; dry heat to the breast and frequent applications of phytolacca cerate; I have had excellent results from this treatment.—Dr. R. Kinsman.

Poultice of hot tea grounds and phytolacca internally or some other indicated remedy; hot lotions of bicarbonate of soda, one dram to the pint of water, for fifteen minutes; dry, apply climax salve; give bell internally and merc. iod. or acon. and merc. iod; repeat lotion and salve as may be required. This plan of treatment is one of the best things I know of in this condition.—Dr. R. N. Foster.

Rubbing carefully with hot olive oil.—Dr. E. J. Jones.

Hot lard, phytolacca cerate, phytolacca 2x internally.— Dr. C. L. Nichols.

Calcarea carb., if temperament fits; bryonia, belladonna; warm applications and rubbing with warm oil, vaseline, etc.— Dr. G. E. Tyler. The bran bag, circular, and pressure.—Dr. Anderson.

Never had one; if I had, bryonia, I presume.—Dr. W. B. Robinson.

Strapping, gentle massage, thorough use of the breast pump; keep the breast well emptied and cake-breast will almost never occur.—Dr. H. P. Holmes.

Bandage and remedies; bell., phyt., hepar; have never had a case go on to suppuration.—Dr. Warner.

Hot vaseline rubbed in from the circumference to the nipple; phytolacca and phosphorus internally.—Dr. H. E. Beebe.

Internally, as indicated, phyt., bell., bry.; warmth and sometimes inunctions of phyt. or bell. cerate.—Dr. G. F. Martin.

Closely fitting bandage, giving much pressure.—Dr. A. Smith.

Phytolacca cerate and dry heat.—Dr. W. I. Tyler.

Brandy and sweet oil, equal parts, applied externally with hand, rubbing quite hard, on a line with the nipple for half an hour at a time on each breast.—Dr. O. S. Wood.

Even support to keep breast at perfect rest, gentle massage, and use, as rarely as possible, of breast pump; internally phyt., merc. sol., bell., verat. vir.—Dr. J. M. Smith.

If not too sore, bathe them with hot lard and apply cotton batting; if swollen and sore, apply cloths wrung pretty dry out of cold water, with plenty of corn meal in the water, and cover them up to keep them warm.—Dr. A. W. Cushing.

Gentle rubbing; phytolacca internally.—Dr. H. C. Aldrich.

Massage is most successful in cases that have not suppurated.—Dr. Sprang.

A properly applied bandage will almost invariably prevent breast trouble.—Dr. L. D. Rogers.

Never allow it to happen; always watch for such things; do not permit such a thing to happen while in attendance. Have had several cases develop three or four weeks after I had dismissed the case, through carelessness of mother, as for instance, in one case one nipple was not perfect; mother

permitted babe to nurse one breast only, which caused caked breast on the other side. In this case lachesis, high, cured. Use no external applications except dry heat occasionally.— Dr. E. E. Reininger.

Do not allow the milk to accumulate in the gland; strap the breast; give phytolacca dec. 3x internally; sometimes use belladonna lotion for twenty-four hours in connection with internal remedy. If no decided improvement in that time I strap, if I think resolution may be brought about; and poultice if, in my judgment, suppuration will occur, and lance as soon as pus is discovered.—Dr. C. G. Highee.

Phytolacca and sweet oil, of each two drams; good early only, as a rule.—Dr. Wilson.

Have used thick lard poultices, but remedies usually avert cake-breast.—Dr. A. H. Tompkins.

Can be prevented by tight bandaging applied in time; when present, in addition to bandaging, bryonia; and later, sometimes, tarantula.—Dr. W. D. Bayley.

Emptying, drawing the milk by hand, mouth, another child, or puppy, but always partially emptying; aided by gentle rubbing with warm hand from base of gland toward nipple; these measures must be persisted in until milk ducts are free and milk flows until breast softens.—Dr. O. A. Watson.

Hamamelis cerate hot, rubbed thoroughly into breast; hold up with bandage.—Dr. L. Allen.

SIGMOID CATARRH IN WOMEN.*

BY CORA SMITH EATON, M. D.

L AST September, at Dr. Pratt's clinic in Orificial Surgery, the subject of chronic constipation and its cure received an extended discussion. It is the gleanings from this discussion, with my own modifications, which constitute the line of treatment I have been following in the past eight months. My cases of sigmoid catarrh have numbered about twenty. The majority of these were suffering from constipation, a few from chronic diarrhea; in other words, the dry catarrh is more common than the moist variety. The results in all have been excellent and in some simply phenomenal. The theory of the treatment is this:

- I. To cleanse the bowel of the superficial coat of mucus by large colon flushings at home.
- 2. By a medicated irrigation at the office, in which an electric current is used to loosen a deeper layer of mucus and also to stimulate the paralyzed muscular coat of the bowel.
- 3. After this double cleansing and stimulation has been accomplished, to inject a medicated oil as high as possible into the bowel, to still further loosen the crust of old mucus deposited and to heal the diseased mucous surface.
- 4. To assist the total results by every means constitutional and systemic, as internal medicines and central faradization.

Before this treatment is attempted every organic trouble should be relieved, such as lacerations, pockets, papillæ, adhesions to clitoris, etc. Special attention should be given to the spine, to make sure it is straight. Some of these cases are occasioned by paralysis of the intestinal nerves following a curvature. To complete the cure requires from one to six months. The treatment should be given every second day at first, then every third or seventh or four-

^{*}Read at Minnesota Institute of Homeopathy, May, 1898.

teenth day as the case progresses. In the interval between the treatments the patient should each day take a large colon flushing to wash away the loosened mucus and that which has been forming during the twenty-four hours preceding. If the patient is too weak to endure the flushings daily, or if there is a daily stool without them, there may be used instead of the flushings four ounces of sweet oil, medicated or not, of the rectum in the knee-chest position. This position is retained until the oil has run up into the large bowel. It will then, in all probability, be held until the bowel movement takes place, unless there is such a clogging of the sigmoid with mucus that nothing can pass without enema.

When the patient comes to the office she is supposed to have cleansed the bowel with from four to twenty quarts of water, taken in the knee-chest position, until the water comes back free from mucus. She is put upon the table with a Kelley pad under her. Cole's sigmoid irrigator is passed into the bowel full-length, and through this are injected from a fountain syringe two quarts of water medicated with two teaspoonfuls of Kennedy's White Pinus Canadensis and two teaspoonfuls of salt. Of course, any other medications can be used, such as hamamelis, hydrastis, calendula, etc.

After two quarts of water have gone into the bowel, I disconnect the syringe tubing from Cole's irrigator and connect the irrigator with one pole of the battery. The other pole is placed on the abdomen. The current used is the primary faradic, interrupted, and is continued for ten minutes. The irrigator is then withdrawn, and the patient allowed to pass the water that was in the bowel, much of which will pass from the bladder, so quickly is it absorbed into the circulation and excreted by the kidneys.

I have had a few cases where the sigmoid was so swollen and coated that not even the finger could enter, and the irrigator could not be passed till treatment had relieved this practical stricture. In these cases I fill the lower bowel with the medicated water through a rectal tube instead of the irrigator, and give the electricity with one pad under the lumbo-dorsal region and one over the abdomen, while the water is in the bowel. In the constipation cases the large flakes and crust of hardened mucus which come away under treatment are startling both as to thickness and quantity. It is not uncommon for a patient to pass, after the electric treatment, a double handful of mucus looking like picked codfish. Sometimes flecks of blood show where scabs formed over ulcers. This mucus and blood gradually decrease until only fresh mucus, like uncooked white of egg, appears, such as is the normal intestinal lubricant.

After the water has come away the patient is put on the table again in the knee-chest position, and a long colon tube is passed full-length: through this is injected by a hard-rubber piston syringe four ounces of oil medicated with oil of tar or eucalyptus or hydrastis. The tube is cautiously withdrawn, and the patient remains in the knee-chest position for ten minutes to help the oil stay where it it is needed.

I have lately found I get almost, if not quite, as good results, and with far less trouble to myself and less discomfort to the patient, by giving the oil simply into the the rectum and having the position retained for ten or fifteen minutes. Sometimes it is a terrible trial to pass the tube, as it kinks in the sigmoid or else hurts the patient unconscionably. After the patient has passed the water, and before I give the oil, I frequently have her lie on a flat electrode and take a spinal secondary faradic cupping. It is a very fine stimulus to the bowel nerves which emege from the spine. Besides that, it starts up contraction in the bowel sufficient to help expel any water which may remain. In the preparation which they make at home I have them medicate the last two quarts with some of the medicines I have named as using at the office. The remedies used by mouth are most frequently hamam. Ix, napthalin 2x, sabad. 3x, and a combination tablet consisting of pepsin, nux vom., and carbo veg., to be taken before and after meals.

This treatment has served to clear up for me so many obscure cases that I no longer grudge the time and effort required to follow it.

THE RELATIONSHIP OF DISEASES OF THE RECTUM TO GYNECOLOGY.*

By Wm. M. Thompson, M. D.

IN writing upon this subject I shall take the usual course of proctologists and include the diseases of the alimentary canal, in so far as they bear upon or influence rectal diseases, particularly Glenard's disease and colitis.

The rectum is responsible for certain pathological conditions of the genital organs and vice versa; first, because of the intimate association of veins; second, because of the intimate association of arteries: third, because they are controlled almost entirely by the same spinal nerves and are surrounded by a ramification of sympathetics; fourth, because their lymphatics either anastomose or empty into common ducts; fifth, a serous membrane, than which no other tissue absorbs faster, incloses a part of both sets of organs; sixth, and last, because of the relationship of the respective muscles, particularly the levator ani and psoas.

The hemorrhoidal plexus of veins is formed by the superior, which enters the upper part of the rectum, through a button-hole loop, and empties into the portal system; by the middle and inferior hemorrhoidal, which empty into the internal iliac and anastomose with the veins of the external genitals; thus we have a connection with two distinct circulations, the portal and the genital venous. The genital veins, named and running parallel with their arteries, form the uterine and vaginal plexuses, the uterine on each side and at the anterior angles of the uterus. Between the layers of the broad ligament this net-work is called the pampiniform plexus. Anterior to this we have the vaginal plexus, anastomosing with the bladder veins, in front of the hemorrhoidal plexus behind. These veins have some valves, the superior hemorrhoidal none, the middle and inferior hemorrhoidal a few; a larger volume of blood from

^{*}Read before the Wisconsin Institute of Homeopathy, April, 1898.

the hemorrhoidal plexus is returned by the superior hemorrhoidal veins.

Robinson says: * "Some of the particular characteristics of pelvic veins are, first, the frequent anastomosis at acute or right angles; second, their large size; third, their large numbers; fourth, some occur double; fifth, some are valveless, and sixth, the aggregation of veins into large plexuses. As a rule, veins in the wall of the pelvis are valvular; those about the organs have no valves."

The pelvic veins are congested, first, by congestion of the liver; second, by force of gravity. The congestion of the rectal veins tends to the congestion of genital veins through their anastomosis. The congestion of veins of either rectum or genitals tends to the congestion of the viscera of the pelvis. The more spiral or curved the veins are, the more healthy; the straighter, the more liable to disease, as in the case of the superior hemorrhoidal, the congestion of which is undoubtedly the most frequent cause of internal hemorrhoids.

As an illustration of this fact, that the rectum is responsible for diseases of the genital organs and vice versa because of the intimate associations of veins, I would cite the following case:

Patient, age forty years; married twenty years; no children; history of miscarriage; complained of hemorrhage from the uterus, bleeding piles, and a rapidly enlarging abdomen. Diagnosis was uterine fibroid, with internal-external hemorrhoids. This was confirmed by an operation, in which the uterus, with the surrounding tumors, the ovaries, and the varicose pampiniform plexus were removed by the abdominal route. At a subsequent sitting the Whitehead operation was performed for relief from hemorrhoids. Inasmuch as the hemorrhoids developed after the uterine trouble, it is my belief that the hemorrhoids were due to the overdistention of the veins of the pelvis, particularly the uterine plexuses.

Before taking up the next division of my subject, I

* Med. Record, N. Y. Vol. liii. B. Robinson.

would like to quote from Reider * in an article on the pathol ogy and treatment of rectal strictures, in which he state that ulcer of the rectum occurs in ten women to one man that in his opinion it is either syphilitic or gonorrheal that the virus is carried through the veins from the genita tract; that microscopic examination has revealed nor mal arteries and markedly diseased veins. Summing up he says:

"First, syphilitic stricture of the rectum does exist Second, it arises from blood vessels; perhaps also from the lymphatics. Third, that this origin is the cause of its relative frequency among women."

The reason for this is that virus taken in by the vulva plexus is carried immediately to the hemorrhoidal plexus

The arteries per se have less to do with the communication of disease within the pelvis than any other structure. The fact that they are under the control of the nerves makes them reflect sometimes the cause of disease. Brown Sequard says that a blood vessel may be contracted either through direct pressure or by stimulation of the vasocon strictor, so as to cause paralysis. Many cases of retrodeviation might be accounted for in this way.

The lymphatic vessels of the rectum are arranged like those of the intestines, generally in two layers; one beneath the peritoneum, and one between the mucous and muscular coats. Immediately after leaving the bowel some of the vessels pass through small adjacent glands, and all finally enter the glands in the hollow of the sacrum, or go higher up in the loin. The lymphatic vessels of the mucous membrane, the labia, the nymphæ, and clitoris terminate in the upper chain of the inguinal gland. The lymphatics of the uterus consist of two sets, superficial and deep, the forme being placed beneath the peritoneum, and the latter in the substance of the organ.

Just as there is an internal and an external system oveins to the pelvic organs, so there is a internal and external lymphatic system; the internal passing into those glands in

* Annals of Surgery, April, 1898, Reider.

the hollow of the sacrum and higher up in the loin, the external passing to the glands in the groin, and these two sets of vessels freely communicate with each other. A knowledge of this fact is of importance in the diagnosis of cancer of the rectum, and the glands which are deep in the pelvis along the sacrum should always be felt for, as well as those located in the groin.

The nervous relationship of the genitals and the rectum is manifested chiefly through reflex action. The spinal nerves hold the vessels in a delicately balanced tension. The sympathetic system holds the rectals and genitals in a firmer and even more delicate balance than do the spinal. Spinal nerves are those which manifest quick and acute pain.

The plexuses of the sympathetic are placed one on either side of the rectum and vagina. Each is composed of prolongations from the hypogastric plexus above, united with branches from the sacral ganglia. The spinal branches of the sympathetic are mostly from the third and fourth sacral nerves. From the back part of the plexus thus formed are given off the inferior hemorrhoidal nerves, which join with the superior hemorrhoidal from the interior mesenteric artery, and perforate the rectal wall. The chief nerve supply of the rectum, as with the vagina, is at the lower portion and around the orifice; the middle and upper portions possessing comparatively little sensibility—so little in fact that the greatest diseases, such as cancer or ulceration, may exist and not manifest themselves by local pain. This external sensibility is derived mostly through the pubic nerve, which sends branches to all the external genitals and perineum and the rectum. We have abundant evidences of the reflex irritability in branches of the pubic Infection of the vulvo-vaginal glands by the gonococcus, producing an exudate which presses upon the perineal branch of the pubic nerve, will cause an irritable rectal sphincter. This portion of the vagina, as well as the lower portion of the rectum, is much more liable to injury than any other region of the pelvis. Injuries from defecation may affect the vulva. Injuries to the vulva during confinement may affect the anus.

This fact led Cripps,* to formulate that well-known law that a long-continued irritation of the nerve of a muscle induces fibrous deposit. The irritation of nerves by an ulcer higher up in the rectum may affect the uterus, setting up a fibrous deposit in the posterior wall. It is a law of fibrous tissue that when inflammation subsides the fibers contract, and so we have a retroflexion caused by contraction of the fibers of the posterior neck of the uterus. The irritation of a nerve may cause vasomotor contraction at the point of irritation and vasomotor dilatation at some other point, as a direct reflex or the reverse. Vasomotor spasm can take place from reflex irritation and the nerve remain in that condition indefinitely or as long as the irritation is kept up. is a rule in the distribution of nerves that the same nerve supplies the muscle and the integument over it. There is no exception in the pubic nerve, supplying as it does the urethra, external genitals, and the sphincter muscles. Operations on the rectum or perineum will cause a retention of urine for several days.

CASE II. Patient aged thirty; occupation stenographer: unmarried; ulcers at the orifice of rectum; retroflexion of the uterus, which caused obstinate constipation; pain in back and down the thighs; great pain in the back of the head; rheumatic pains in both arms and shoulders; writer's cramp, which compelled her to resign her position; operation: curettement and shortening of the round ligaments, together with the removal of the rectal ulcers. The reflex pains gradually disappeared, and the patient made an uneventful recovery.

This case illustrates what we often see in gynecological practice, the reflexes that may result from nerve pressure. Adhesions may and do frequently take place between an inflamed and misplaced uterus and the rectum, through the peritoneal coats. A condition of this sort usually results in constipation. A blockade of the rectum causes an abnormal

#" Fox on the Sympathetic."

distention of the sigmoid, and the sigmoid being freely movable, tumbles over the brim of the pelvis, and we have an addition of troubles which I shall describe farther on, and under the head of enteroptosis.

Byron Robinson * says that muscular trauma may often be the cause of pelvic disease; that the levator ani, by its friction and association, is prominent in the spread of this disease. In studying the result of muscular trauma, we should include the sigmoid and the cæcum. In three hundred personally reported autopsies Robinson says: "I found the meso-sigmoid possessed peritoneal adhesion in over eighty per cent. of subjects and in quite a number of cases fimbriæ of the fallopian tubes were found adherent in the region of the highest range of the action of the psoas muscle. In such cases the meso-sigmoid and tube became diseased through the traumatic action of the psoas muscle, inducing the migration of virulent microbes and other products. In the case of the fallopian tube, the psoas muscle induced the migration of infective germs from the tube lumen and the perineal surface. In the case of the mesosigmoid, the traumatic action of the psoas on the sigmoid, at the times when it contained virulent germs, induced the migration of the germs, or other product, through the gutwall into the perineal surface, causing plastic peritonitis. Here the meso-colon and tube became pathologic from the same cause; that is, muscular trauma of the psoas magnus. Similar disturbances occurred on the right side of the appendix."

In 1885 Glanard first described the disease which bears his name, and which to my mind, as I hope to show you before completing this paper, is a powerful clinical factor in diseases of women. Strange to say, the gynecologist has overlooked this disease in a majority of his investigations. Such books as Pozzi contain no reference to it. The other day I took occasion to search through a large number of text-books for some recognition of enter-

^{*} Med. Record, N. Y. Vol. liii. B. Rotinson.

optosis, but failed to find any. Ewald * probably gives it as much notice as any of our modern writers, but I do not remember seeing it mentioned in a text-book on diseases of the rectum. The nomenclature of this disease is somewhat mixed. We hear it described as Glanard's disease, and sphlanc-noptosis, gastoptosis, heptoposis, enteroptosis, etc. In speaking of its relationship to gynecology I like the word enteroptosis, as Glanard has described it. The symptoms are dyspepsia, nervousness, etc., neuræsthenia, lassitude, headache, obstinate constipation, or constipation and diarrhea. The pathognomonic system is a dragging sensation in the lower part of the abdomen, with pulsation over the solar plexus.† This disease is impossible in animals for the reason that animals do not walk erect: consequently, the abdominal organs are not suspended by ligaments, as in man. The disease begins in the hepatic flexure of the colon. Then the whole of the transverse colon gives way, dragging the stomach with it. Following this the ascending and descending colon, particularly the descending, with the sigmoid flexure become displaced. These organs fall into the pelvis and disorganize all its functions. The pulsating tumor, at the point where the transverse colon should be felt, is often mistaken for aneurism of the abdominal aorta. Lund t says: "The pressure in the stomach of a patient in an upright position, measured by an anameter is eleven cubic centimeters of water; in the rectum thirty-nine cubic centimeters. The relaxation of the support by a ruptured perineum or a prolapsed uterus will greatly lessen the intra-abdominal pressure. Displacement of the uterus, pelvic tumors, etc., interfering with the pressure on the rectum, will increase the pressure within the rectum and intestines. Over-distention of these organs causes relaxed ligaments. Relaxed abdominal walls from over-stretching, as in pregnancy, will lessen intraabdominal pressure."

^{#&}quot; Diseases of the Stomach," Ewald.

[†] Boston Med. and Sur. J. Vol. cxxxvii. A. K. Stone.

Boston Med. and Sur. J. Vol. cxxxvii. Lund.

The following has been an axiom of mine in the diagnosis of enteroptosis: Chronic distention of an intestinal wall will not only weaken the wall, but also the ligaments that support that intestine and cause ptosis. We must not overlook the clinical importance of impacted and pelvic tumors as being a predisposing cause of distention of the intestines, nor the importance of rectal palpation of these tumors.

Membranous colitis is nearly always an accompaniment of this disease. Pantzer,* in an article on membranous colitis, and its relations to the diseases of women, says: "Diseases of the signoid and Glanard's disease are of great importance. Membranous colitis is not a nervous disease, but the conditions are due to the saprophytic toxins. Colitis often exists in old retroflexions or left lateral displacements of the uterus; also in cases of impacted tumors of the pelvis. The disease should be suspected in every case of chronic pelvic disease, and is often mistaken for chronic malaria."

Enteroptosis occurs more frequently in women than in men. In Glanard's 403 cases, 306 were women. Tight lacing and pregnancy are the chief causes of this great difference in the two sexes. Chlorosis is said by Meinert to be a constant symptom of this condition. Indeed he maintains that enteroptosis is one of the chief causes of chlorosis in young girls.

To conclude: 1. Because of their anatomical relationship the rectum and genitals affect each other in disease.

- 2. The rectum should not be overlooked in the diagnosis of pelvic disease.
- 3. The abdominal organs should not be overlooked in the diagnosis of pelvic disease.
 - * Ann. of Gyn., Boston, 1896-97. Vol. x. Hugo Pantzer.

THE IMPORTANCE OF CORRECT DIAGNOSIS IN GYNECOLOGY.

BY A. E. NEUMEISTER, M. D.,

Professor of Gynecology, Kansas City Homeopathic Medical College.

ORRECT diagnosis is of greater importance in the gyne-Cological department of medicine and surgery than in general diseases. Patients who call on the gynecologist for diagnosis and treatment have usually already been in the hands of general practitioners of both schools, who perhaps trusted too much in symptomatology. It is certainly impossible to cure with remedies a case of backache caused by dermoid cyst, which may be attached to the broad ligament and adhered posteriorly. I had a case, a young lady, aged twenty-two years, who had never been strong since she was a child, and had suffered a great deal with backache and tired feeling. There was a great deal of distress with the bladder with copious urination, worse during the day, and better when in bed or lying down. The patient had been treated for six years with remedies, without relief. Several physicians had treated her for retroversion of the uterus, but had failed to relieve her backache. When she came to me for diagnosis I put her under an anæsthetic, made a bimanual examination, and found a soft tumor a little larger than a cocoanut in the posterior cul-de-sac, which I diagnosed as a tumor with posterior adhesions. I afterward had the opportunity to remove the tumor, and found it to be a dermoid cyst.

CASE II. A lady who had suffered ever since her last child was born, which was six years ago. This lady had all the symptoms of at least fifty remedies. She had employed both schools of medicine, and her case had been diagnosed as about all the diseases a woman is subject to, but no one had given her relief. I had the opportunity to examine her under an anæsthetic before the class, and found a small ovarian tumor on the left ovary, which made an operation necessary. I performed the operation and found the tumor and a small cyst, and the omentum was adherent to the fun-

dus uteri and the broad ligament. I removed part of the omentum, broke off the adhesions, and removed the tumor. The operation permanently cured this case.

CASE III. A lady who had suffered for years with colic pains, which almost doubled her up. Sharp, shooting pains came and went. She had the severe colic in the intestines which called for colocynth, and many physicians had prescribed this remedy without the desired effect. This case came to me for a diagnosis, and I found upon examination a very small vagina and abnormally small uterus drawn up and immovable. I made a vaginal hysterectomy, and found the omentum adhered to the fundus uteri. The operation cured the colic, and the patient is free from pain.

CASE IV. A young lady who suffered severe, bearing-down expulsive pains during her menstrual periods. She had been treated for four years. Some of our most skillful medical prescribers had prescribed for her, but no remedy would relieve her pain, except morphine, which only gave temporary relief. This case also came to me for a diagnosis, and I examined her under an anæsthetic, and found two small ovarian tumors with adhesions. I urged an operation and removed both tumors. Both ovaries were inclosed in the tumors filled with blood clots. The operation relieved the patient entirely, and she has had no pains since.

CASE V. A young woman, aged twenty-four years, who had suffered ever since her first menstruation with repeated attacks of painful menstruation. I treated this case with remedies from year to year. She left me and had several other physicians prescribe for her, but they also failed. Finally she was married, became pregnant, and was delivered of a baby girl; but soon the baby died of inanition. The mother had a severe laceration of the cervix and leucorrhœa followed. Her monthly suffering became worse, and I was called upon to perform trachelorraphy. I did so, and while she was under the anæsthetic I made a careful examination, and found an ovarian tumor on the

left ovary, while the right ovary was so large that it had certainly lost its function. She had only menstruated occasionally, and I told her she would never be relieved until an operation was performed. On April 5, 1898, I performed a laparotomy on this lady in the presence of our post-graduate class. I found on her left side an ovarian cyst, and the ovary was three inches in diameter, filled with blood clots and fluid. The whole mass was surrounded by adhesions. The right ovary was two inches in diameter. One-half of it contained fluid, while the other . half was white, wrinkled, and bloodless. The tubes were congested and enlarged. I removed the tubes with the ovaries, and closed the abdominal wound, leaving a drainage tube for five days. The patient made a good recovery, and claims that she has not been so free from pain for five vears.

I could name scores of cases similar to those just mentioned. Patients who were treated by the best medical talent in the country, and never got permanent relief from medicine, were cured by operation. I think in all cases where our homeopathic remedies fail to relieve pain, whatever the trouble may be, we should certainly think of some abnormal condition which should receive the utmost attention of the family physician, and a careful examination should be made under an anæsthetic only. It is misleading in the majority of cases to undertake an examination without an anæsthetic. I have no trouble in making a diagnosis when the examination is made under an anæsthetic, and I would prefer to lose the patient than to make a mistake in diagnosis.

THE ARMAMENTARIUM OF THE OBSTETRICIAN.

By J. W. MEANS, M. D.

DURING the year past there have been no startling discoveries in the science of obstetrics. The laws governing the mechanism of labor have not changed. No new remedies have been found to relieve the pangs of labor, or avert the dire results of incompetency, negligence, or uncleanliness, on the part of the attending physician.

In one direction alone there has been advancement, viz.: in the belief that cleanliness is next to godliness; and that septic conditions following child-birth arise from external causes, and in a vast majority of cases the accoucheur is the medium by, and through which, the infection is transmitted to the patient.

The midwife points with pride to the fact, as gleaned from statistics, that septicæmia was not as prevalent during the days of her supremacy as at the present time. The explanation of this somewhat startling fact is this: The midwife never examines the patient, she trusts to nature, consequently she does not carry infection to the patient; negatively she is a success; affirmatively she is a grand failure. It is a remarkable fact that woman having had the position, national backing, and seemingly Divine sanction to be mistress of ceremonies on such occasions, has not made as much progress during all the past centuries as man has made in ten years. The midwife of to-day is as ignorant of the mechanism of labor as she was two thousand years ago.

Natural labor is the rule—that is, the child presents itself in the normal position and, unaided, completes delivery in twenty-four hours. Dr. Smellie calculated that 990 in every 1000 are natural labors. So it is not strange that anybody who has the good sense to let the mother alone will have a certain degree of success.

When a physician is called to a case of confinement, he should be prepared to meet any emergency. Yet it is not

expected that every physician should be a walking arsenal.

The first, and in fact, the most important requirement of the up-to-date obstetrician, is perfect cleanliness. The profession is a unit in insisting upon asepsis of instruments, patient, and self. In the Sloane Maternity, New York Maternity, New York Polyclinic, University Maternity of Philadelphia, and Boston Lying-in Hospital, the bichloride douche (1-5000) is given at the beginning of labor to insure the aseptic condition of the vagina. At the New York Post-graduate Hospital, and the New York Lying-in Hospital, no internal disinfection is practiced, excepting in cases where there are known to be unhealthful discharges.

To prove to the profession the efficacy, or inefficacy of this mode of procedure, a number of careful observers have made a thorough test of this matter, and the conclusion is that "disinfectant irrigation of the vagina before labor, in normal cases, is more often harmful than helpful."

The investigation of Döderlein and Kronig shows that the normal secretions of the vagina will not only prevent the growth of pathogenic germs, but will destroy these artificially introduced.

Uncleanliness in a physician who has charge of an obstetric case is a crime, and he should be punished accordingly. Puerperal infection in private practice prevails to a greater extent than is generally believed, for which condition the attending physician must hold himself responsible. Intra-uterine or vaginal irrigation after birth should not be practiced except in rare cases, such as forcible removal of the placenta, and after instrumental delivery when contusions and slight lacerations may have occurred. The advocates of antiseptic medication, as taught by Kister, have in some instances gone beyond the bound of common sense, and have subjected our patients to unnecessary risk with their microbe-killing devices. Plain cleanliness is all that is necessary.

The second division of my subject, under "Medicinal Aids" will receive our attention.

There are five important remedies, viz., cimicifuga, gelsemium, arnica, morphia, and chloroform, that may be needed in all cases of confinement or during the gestation stage.

I am an advocate of cimicifuga as a parturifacient. I prescribe this remedy in the 3x trit., three or four I-gr. tablets, morning and evening during the last month of gestation. Experience has proven to me that cimicifuga has a tonic effect on unstriped muscular fibers, and that it shortens labor, quiets that anxious, nervous, irritable condition so often present, and is beneficial in many other ways.

The next important remedy, where the os uteri is hard and tense, unyielding, pains irregular and ineffectual, is gelsemium. 10 gtts. in 3 ij of water—a teaspoonful every ten or fifteen minutes until dilatation takes place.

Arnica, after delivery of child, will relieve soreness of muscles, mechanical injuries, and contusions. For after-pain a host of remedies is highly recommended. Some authors give indications for fifty drugs—more modern obstetricians are less expansive in their views, and give a list of twenty-five drugs from which to select; but after you have tried them all, and worried your patient well-nigh unto distraction, give ½ or ½ gr. sulph. morphia, and you can rest assured that relief will follow.

The last, but by no means the least, is chloroform. This is a *humane remedy* and can be used in at least twenty-five per cent. of all obstetric cases to advantage.

MECHANICAL AIDS.

The instruments that a physician should have at hand depend upon circumstances. The one important instrument is a pair of forceps. I have practiced medicine sixteen years, and never had occasion to use any other than a short forceps (Simpson's). It is a remarkable fact how frequently or infrequently the forceps can be used. In England statistics show that forceps are used in 1-360 cases. In my own practice I use the forceps in ten per cent. of all my

cases; not because it is absolutely necessary, but oftentimes you can relieve the mother of hours of severe labor: in doing this you conserve her strength and subject her to no risk.

As to placental forceps, none has ever been made equal to the hand—perforators, craniotomy forceps, cranioclast, cephalotribe, and numerous other contrivances, may be needed, but to my own personal knowledge, I never used them.

When laceration of perineum occurs, it is expected that the physician immediately repair it, according to the most approved method. I am glad to state that, since using less ergot and more chloroform, the number of lacerations has been materially reduced.

Never use forceps without first immersing them in boiling water, then lubricate with pure lard, which you should have with you (quarter pound pure lard in glass jar). After birth of child tie the umbilical cord with a sterilized ligature; and cut it with scissors made sterile also.

Various opinions have been expressed as to the time to cut the cord, and what effect it has upon the child. Meyering advocates the late cutting of the cord, because the greater amount of blood the child receives from the mother, the more robust it will be.

Engle found from his investigations that, in the case of children in which the umbilical cord was tied immediately after birth, 18.88 per cent. died within the first eight days: and in those in which the cord was tied late, 9.45 per cent. died within the same time. Schiff recommends an early ligation of the cord, because, as he says, it is to the advantage of both mother and child. He argues that in late ligation the blood vessels become engorged and temporary irritation of the blood and lymphatic vessels arises, and frequently causes a diseased condition known as icterus. Again there is a number of reputable physicians who advise that the cord be not tied at all! Were it not for the danger of the child bleeding to death, it would seem that this latter class had struck the golden mean.

The first dressing for the navel is important—I here show you an aseptic dressing consisting of two or three layers of sterilized gauze.

Next is the knit bandage, which should be used, and which should be furnished by the physician. The vaginal pad for the mother, carefully antisepted, is of vital importance, as any old rag, dragged from the closet, is liable to be applied if you are not particular. What I wish to impress you with particularly is that cleanliness is always demanded if you expect success. Medicine and instruments are of secondary importance, as thousands of physicians have practiced obstetrics scores of years and never used either.

ADDENDA.

The above essay is a truthful statement of my experience with instruments, ending April 24, 1898, at which time I finished this above article, and felt sure that it could not be controverted.

April 26, 1898, was called to a lady in labor—had been suffering severely for twelve hours—twelve hours later the os was fully dilated and the head firmly lodged in the upper straits; I then applied my forceps, my short ones, which had served me for sixteen years, and after three hours of extreme labor on my part, failed to accomplish anything. I then sent for an assistant, whom I knew had Hodges' long forceps. Chloroform was administered, and the doctor proceeded to deliver the woman with his long forceps. After another hour of delay and labor, we had not moved the child an inch. We then concluded to use a perforator, and craniotomy forceps, which I did not possess, and the consultant failed to find in his satchel. However, they were procured; and after completely destroying the bony arch, of the head, and with aid of the long forceps, the child was born.

I mention this somewhat remarkable incident as a warning to those who have for years drifted along and have become fully inured in the belief that the many instruments and fixtures advocated by our authors in obstet-

rics were devices of the devil, and only incompetency, and a grandiloquent desire to display instruments of steel by the ambitious M. D., led to their use.

I now advise that every physician have within his grasp a complete set of instruments that might be necessary, whether they should be used once in sixteen years, or once in thirty-two years.

TYING AND DRESSING THE UMBILICAL CORD.

BY H. D. CHAMPLIN, M. D.

1. Is it necessary to tie the cord?

I do not believe it is, but custom and teaching largely guide us in such matters, and the average practitioner does it because he is afraid to make any innovations.

I experimented last year in a series of cases (ten in number) and left the cord without a ligature, and had no ill results.

"One swallow does not make a summer." Ten cases is too small a number to flaunt before the critical eye of the medical profession as being authoritative. It may serve as a nucleus for others to build on.

2. When should the cord be tied?

Given a lusty child, whose respirations are full and strong; I ligate the cord at once.

Child is puny, feeble, respirations shallow; I wait 10, 15, 20 minutes, before ligating.

3. Where and how should the cord be tied?

Ligate cord one inch from the umbilicus.

The past two years I have used Dr. Kellogg's Funis Band Application and rubber bands, and find they are an excellent innovation upon the time-honored "linen thread," or "silk ligatures." Since using these bands I have had no ill results.

4. Dressing the cord.

A piece of absorbent cotton 4 x 4 inches is cut, the sur-

face freely sprinkled with a preparation of acetanilide. Boric acid aa; the stump covered with same preparation, cotton laid over and then folded around the stump, which is turned up on the left side and held there by a bandage.

This dressing is not disturbed, and the cord usually drops off the fifth day, and needs no further attention.

My babies, save the face and eyes, receive no baths until the sixth day. They are anointed freely the first five days with lard which has been rendered at home, and the surplus removed with a soft towel.

Such babies do not catch cold, are not cross, and thrive from the very first.

IMMEDIATE REPAIR OF CERVICAL LACERATION.

By Susan J. Fenton, M. D.

IF it be true that "the physician's highest and only calling is to restore health to the sick," and if it be true that "the highest aim of healing is the speedy, gentle, and permanent restitution of health, or alleviation and obliteration of disease in its entire extent, in the shortest, most reliable, and safest manner according to clearly intelligible reasons," it is also true that immediate repair of injury to the cervix uteri after parturition is not only allowable, but incumbent on us who aim to live by the above statement; and I believe the time is not far distant when it will be counted as great an indication of incompetency for an obstetrician to neglect repair of cervical laceration, in suitable cases, as it now is to neglect perineal lacerations.

What cases are suitable? In any case in which we can do immediate perineorrhaphy, we can also do immediate trachelorrhaphy.

I do not mean to say that all cases of perineal repair call for cervical repair, for we often have quite extensive injury to the pelvic floor, with no laceration of the cervix which needs repair, for a laceration of the first degree only needs no stitches, as it will heal properly if left to itself. But there are two classes of cases in which I think the best interests of our patients demand operation:

First, when the laceration extends through the circular artery, and this is essentially the operation of necessity, for there is no other way compatible with aseptic midwifery to control the attendant hemorrhage. The second class of operation of election should, I believe, be done (except in those rare cases when any operative procedures are contraindicated by some peculiarity or condition of the patient) in all cases where the rent is beyond that of the first degree; and by first degree I mean one which only involves the mucous surfaces and does not extend into the muscular fibers to any extent.

A neglected cervical laceration enhances the danger of sepsis in the puerperium, and we are all familiar with its health-destroying train of after-effects: The uterine subinvolution, chronic venous congestion and inflammation, cervicitis, endometritis, erosion, leucorrhœa, prolapsus from weight, and innumerable manifestations of nerve disorder which may, through the great sympathetic system, show itself in the most remote parts of the body.

To believe that the operation interferes with drainage is a mistake. By coapting the raw surfaces one of the avenues of germ entrance is shut off, the canal is left in a normal condition, and is as properly fitted to drain the uterus as are non-lacerated cases.

The technique is very simple: hands and instruments are made perfectly aseptic, the latter by being boiled; the patient is placed crosswise on the bed with the hips well to the edge. I prefer the dorsal position, because there is less disturbance to the patient and she is then in position for perineal work later. If there are assistants to hold the legs, good; if not, a long towel or any stout cloth put around each knee, brought alongside the body, and pinned firmly to the mattress serves the purpose as well as a leg-holder. The few instruments needed are placed conveniently at the right hand; volsellum forceps, needle-holder, and needles armed with silkworm-gut suture are all that are positively

necessary. If there is an assistant to hold it a Sims speculum, to use as a posterior vaginal retractor, is an advantage. Each lip of the cervix is caught by the volsellum forceps and brought well down to the vulva, a needle threaded with silkworm-gut suture is passed deeply at the angle through the posterior lip of the left side, emerging just at the edge of the mucous membrane of the canal. It is reinserted into the anterior lip just at the mucous edge of the canal, and emerges at the angle of the tear in the anterior lip. The remaining stitches are passed in a similar manner on both sides, although I have found it somewhat easier to pass them on the right side (patient's), through the anterior lip first. When the sutures are all placed they are tied more tightly than in the secondary operation, owing to the cedematous condition of the cervix.

After the sutures are all tied and the ends cut, the uterus is replaced and the attention turned to the perineum.

THE SURGICAL TREATMENT OF DIPHTHERIA, WITH SPECIAL REFERENCE TO THE METHODS AND ANATOMICAL RELATIONS OF TRACHEOTOMY.*

BY E. B. ROCHE, M. R. C. S., L. R. C. P., Physician to the Norwich Homeopathic Dispensary.

MORE than twenty-five years ago I read a paper before the Medical Society of King's College on this subject. and the chief point which occupied attention then was the question of "high" and "low" operation. In those days there were stanch adherents of each, and it was constantly discussed; but after so long a time, finding that this question still claimed attention, I propose again to take the matter up.

In a few sentences let us recall the anatomy of the area

^{*}Presented to the Section of Surgery and Gynecology, December 2, 1897. Journal of the British Homeopathic Society. Also the articles by Drs. Day and Moir, and the discussion following.



involved. Beneath the skin, on either side of the median line, are the anterior jugular veins. Their size and exact position vary; at the lower part they diverge, and are frequently connected by a traverse communicating branch. Next comes the cervical fascia inclosing the muscles, extending from above downward, in front of the trachea. Beneath these the isthmus of the thyroid crosses the second, third, and fourth rings of the trachea. Eight rings are usually seen above the sternal notch. Above the isthmus a transverse branch between the superior thyroid veins is found. Over the isthmus is a venous plexus, from which the inferior thyroid veins arise, while below the isthmus these veins lie in front of the trachea, with the thyroidea ima artery, if it exists. The inferior thyroid veins may be in single trunks, or form a plexus. The thymus gland extends upward in young children to a variable distance, and the innominate artery and vein cross the trachea about the seventh and eighth rings, or even higher in some cases. The isthmus of the thyroid is the crux of the question of "high" and "low," the tube being placed in the trachea above or below that structure. Above, the first two rings of the trachea give little room, and bring the tube very close to the larynx. Below the isthmus the dissection has to be carried much more deeply to reach the fifth and sixth rings. In young children the depth of the trachea below, the short, fat neck, the presence of the thymus, specially contra-indicate a low incision, while above the high crossing of the isthmus necessitates the division of the cricoid, and still closer approach to the larynx.

In former days it was considered that to cut the isthmus was dangerous, while above it and below it an insufficient area presented itself. Accepting the importance of the isthmus and the danger of serious bleeding; observing also the transverse vein above and the plexus below, the possible presence of the thyroidea ima, and the great desirability of a larger and clearer area for opening the trachea, namely, the third, fourth, and fifth rings, I proposed to avoid the contest as to "high" and "low," and secure the best area

in the following manner: An incision of 13/4 to 2 inches being made from the cricoid downward, the fascia divided, the muscles separated, and the isthmus reached, an aneurism needle threaded with a silk ligature is insinuated beneath it from above, and carried on for half to three-quarters of an inch along the surface of the trachea, the point then brought forward, and the ligature divided, each ligature slightly drawn to its respective side and firmly tied. The band of tissue between the tissues is then divided by scissors, and the lobes of the thyroid and the vessels connected with each slightly drawn to each side, leaving the second, third, fourth, and fifth rings clear. The ends of the ligatures are laid on each side for the time being. The rings most to be desired are now in view, and there is no necessity to approach the larynx too closely, or divide the cricoid, or to work in a dangerous and difficult spot below.

To keep exactly in the middle line is the guiding rule of tracheotomy, and when the trachea is bared this holds good in the highest degree. The trachea must be incised in the middle line, and the incision must be exactly vertical, and sufficiently free.

On this depend the prompt insertion of the tube and its comfortable fitting afterward. If the incision be to one side or diagonal the tube cannot be properly located, and there is sure to be trouble, while, if the incision be too small, the operation is gravely complicated. The trachea is divided by the scalpel from below upward. Entering with a puncture, so as to carry the point into the caliber of the trachea, through the mucous membrane, and any exudative layer (if such there be), the rings are sufficiently divided. If the handle of the scalpel be instantly made to follow the incision of the blade, and then turned on its own axis, and pushed upward, the trachea is at once affixed, the incision opened in triangular form, and the handle forms an infallible director, along which the tube is carried into the trachea. The importance of thus clearing the surface of the trachea, and seeing the rings, is emphasized when, from our own experience and that of others, we recall incisions misplaced even to the extent of missing the trachea altogether, wounding the esophagus or carotid artery, or even placing incisions on the surface of the vertebræ. In performing this operation it is very important to have the patient on a table sufficiently high, as otherwise the operator will find himself greatly hindered. The patient should be well wrapped round so as to control the arms; and in most cases an anæsthetic is to be used, the neck made prominent by a supporting roll, the head thrown back, the line of the body well preserved, and the middle line well defined.

The cricoid cartilage is the guide and starting point. As a matter of fact the thyroid isthmus does not bleed so very much if incised in the middle line, and if the fascia is properly divided it can be pushed down a good deal, but to obviate all risks from it, or any related vessels, and to free the trachea to a comfortable extent so that eye and finger can carefully locate the incision to the greatest advantage, I proposed, and still advise, the use of the ligature. If, owing to the congestion of parts caused by difficulty of breathing, there is any considerable amount of oozing hemorrhage, it is best checked by at once making the tracheal incision, and the insertion of the tube. The use of the tracheal hook I have not found necessary; the scalpel handle, used as described, fixing and raising the trachea, and insuring the placing of the tube. The triangular opening of the tracheal slit gives free passage to the air at once and allows the expulsion of mucus or membrane prior to the placing of the tube. No tracheal hook, dilator, or pilot is needed, and thus three special instruments are eliminated. Retractors are in most cases unnecessary, and, where the work is single-handed, impossible. The end of one of the ligatures passed behind the neck, and gently tied to that of the opposite side, may be helpful in this case to keep the lips of the wound open. The absolute certainty of the tube being placed in the trachea is a most important matter, as it is common knowledge that the tube has again and again been pushed down in front of the trachea, where a low operation, a scanty tracheal incision, and the absence

of a certain guide contributed to this most mortifying conclusion.

Comfortable fitting of the tube, and the tube so shaped that the lower end shall not press against the tracheal wall, either anteriorly or posteriorly, are of vital importance. Ingenuity has found expression in the bivalve of Fuller, the angular tube of Parker, and the fishtail of Durham, which are the principal types of an extended and minutely varying armamentarium. Ulceration into the esophagus and innominate artery are recorded results of ill-devised or ill-adjusted tubes.

The after-treatment is all-important. The tube, which should be ready provided with tapes, should be at once tied in; a little shield of protective overlaid with gauze should be slipped under the collar of the tube, a dust of boracic acid being useful as these are replaced from time to time. A piece of gauze laid over the mouth of the tube will protect it, and intercept coughed-up mucus. The importance of good nursing and management of the tube cannot be overstated, being more than half the battle. It may be necessary to clear the tube every hour at first. For cleansing the tube, as well as for spraying in case of dryness, a solution of bicarbonate of soda, gr. x ad 3 i, is very useful. Sudden obstruction of the tube is more often due to inspissated mucus, and the use of the alkaline spray helps very much to mitigate this. If there is evident obstruction in the trachea, feathers moistened with the soda solution may be passed through the tube, and twisted round to free it. There should, however, be no needless meddling. Generally, with good management and care, the little patient can swallow nourishment. If; however, as is sometimes the case after this operation, food cannot be taken, owing to its invasion of the larynx, it will be necessary to pass a small india-rubber tube, or flexible silk catheter, through the nostril, into the esophagus, and administer liquid nourishment through it. Be sure the tube is in the esophagus. The tracheotomy tube should be got rid of as soon as possible, as the longer it is in place the more difficult, or even impossible, it may be to dispense with it. Where there is need for delay an india-rubber tube of reliable make may be substituted for the metal one with advantage, and this can be curtailed from time to time till little more than the shield is left. The act of breathing through the larynx having fallen into abeyance, this is the most frequent cause of difficulty, but there may be granulations, contractions, or adhesions, which will have to be dealt with from the tracheal opening before the removal of the tube can be accomplished. MacEwan's & Stoerk's tubes may be helpful in these difficult cases, and much patience and ingenuity are required to meet the spasm, fear, and temper which are all elements in the difficulty experienced in getting rid of the tube.

The success of tracheotomy depends very much on the point in the case at which the operation is performed. If it be looked upon as a last resort, and the condition of the patient is very serious before it is proposed, few recoveries can be expected. The first distinct symptom of extension to the larynx, though the constitutional symptoms may be slight, should determine the time and need for tracheotomy. The operation is required to obviate the conditions of spasm and obstruction of the larynx, and not in any sense to cure the disease. Its use is to preserve the patient from asphyxia and death, and thus secure time, in which treatment and the course of the disease may work out a successful issue. The new treatment by antitoxin serum is on its proof and trial, and if used early, and acting with the success claimed by many, will doubtless reduce largely the need for operation. In cases, however, in which the disease has made some progress, with early laryngeal symptoms, the operation is called for, while the treatment of the disease is continued either by the serum or ordinary and various medicinal agents. In any case where the patient is not manifestly moribund by reason of the lethal constitutional effects, and where the laryngeal obstruction is prominent, it is merciful to give the patient relief if possible from the painful death by strangulation, and save the friends from witnessing so

distressing a termination. It must always be remembered, too, that to gain time, with possibility of treatment, and mitigation of symptoms, is our duty, and therefore not to be neglected, through taking a hopeless or gloomy view of the patient's condition. The case of an experienced surgeon who, being called into the country to perform tracheotomy, declined to operate because the case was hopeless, and yet the child recovered, should remind us that none of us are infallible, and that while there is life there is hope.

There are many other points of practical interest and matters of detail, connected with the operation and after-treatment, which, as matters of opinion, would afford material for discussion, did time permit. The points which I personally wish in closing to emphasize are, that an effort should be made to simplify the operation in every way as regards instruments, and the necessity for assistance; and that, abandoning all question of an operation, "high" or "low," we should free ourselves from this needless and embarrassing limitation, and so act as shall enable us safely to place our incision and insert our tube at the point we may judge to be the best.

THE SERUM TREATMENT OF DIPHTHERIA.

By J. ROBERSON DAY, M. D.,

Physician for Diseases of Children to the London Homeopathic Hospital.

A T the present day, when serum-therapy has been so largely occupying the mind of the medical profession, an evening which has been devoted to the consideration of diphtheria in all its aspects would be incomplete without some reference to the antitoxine serum treatment.

I shall endeavor to briefly describe the use of serum in treating diphtheria. Confining myself to its therapeutic application, illustrating my remarks from cases under my own observation, and then bringing before you statistics based on our own hospital cases; and secondly, statistics compiled from allopathic sources.

CASE I. My first case occurred in February, 1896. M. W., girl, aged six and a half, was perfectly well on the morning of February 8, 1896; at 7 P. M. the same day she complained of sore throat, and the temperature was taken and found normal. She passed a very restless night, with frequent empty retching. Next day, February 9, I found temperature 104° F., both tonsils enlarged and covered with patches of exudation, and also some patches on the pharynx. The glands at the angle of the jaw were enlarged and tender. Scarlatina was suspected, but no rash was found on the chest. I gave belladonna 3 and aconite 3x alternate hours. Qnoting from my notes made at the same time, I read:

February 10.—Very delirious last night, but better this morning, and temperature 102-6°, pulse 132. The cervical glands on the left side much enlarged and tender; tonsils swollen and covered with exudation membrane, like severe tonsilitis. There was no rash on the body anywhere. She was feeling better and taking nourishment well. At 10 P. M., temperature was 99.6°, with delirium at times and fetid breath. Tonsils covered with a suspiciously diphtheritic membrane; glands on the left side very much swollen and tender. Medicine changed to mercurius biniod. 3x, gr. i every two hours, also a gargle of weak permanganate of potash, and hot fomentations and a steam kettle ordered. Diet: milk and Vichy water only.

February 11.—Passed a restless night, but was less delirious, and is brighter and has taken some nourishment. To-day is quite rational. Throat is now covered with membrane on both tonsils, which meet. This was the third day of the disease. At I P. M. I injected 14 c.cm. of antitoxin serum into the loin, but continued the merc. bin. 3x, and also sprayed the throat with diluted Hydrozone. Diet: in addition to milk and Vichy water, Valentine's meat juice, 3j ter die, and brandy, 3j in twenty-four hours, as the pulse was weak and 126. At 8 P. M. the throat was examined and a piece of membrane stripped off (which caused free bleeding) and sent to be examined.

I may here say that all my cases have been submitted to the bacteriological test, which in doubtful cases has proved of greatest value.

There was to-day a thin offensive discharge from the nose, showing the membrane had extended into the posterior nares.

February 12.—Decidedly better—slept at one time one and a half hour's quiet sleep. Is brighter, and had no delirium last night. Throat less red, glands less swollen. Nose still discharging, fetor less; 10 c.cm. again injected, merc. bin. 3x continued. At 5.30 P. M. swallows more easily, membrane not extending; urine, opalescent with albumin, on boiling.

February 13.—Passed better night, some good sleep; temperature normal; membrane looks to be detaching itself, and at 6 P. M. was clearing from the throat. Asked for and ate some bread and butter.

February 14.—Very much better this evening. Coughed up a large piece of membrane.

February 15.—Improvement continues. Breathes through the nose. No membrane can be seen in the throat. A measly rash appeared about the elbows and buttocks. Progress now continued steady, and on February 19 china Ix was substituted for biniodide of mercury.

February 24.—A slight nasal twang was noticed in her voice; this continued, but the paralysis never caused regurgitation of fluids through the nose.

March 6.—Had slight sudden pallor, and again on March 9, when the knee-jerks were found absent.

March 10.—Heart's beat irregular, and strych. phosh.

March 16.—Eyesight noticed defective, and on March 20 there was marked strabismus from paralysis of right external rectus, with diplopia; all things looked double. Shortly after she left for Exmoor, and on her return the squint had disappeared, but the knee-jerks were still absent. This, I have before observed, is a most persistent symptom.

I have given the notes of this case at some length

because it was my first case treated with serum, and the type was severe; paralytic sequelæ were marked and varied, and, what was most satisfactory, complete recovery followed.

CASE II. My second case was also one of severe type, in a lady aged fifty-eight, and but for the serum I believe she would have lost her life. I saw her first on July 2, 1896. She had been ailing some days, and two days before I saw her felt the throat sore. The temperature was normal, but had been 101°. Has had headache and no sleep. The right tonsil was found enlarged, inflamed, and ulcerated. The lymphatic glands were enlarged. I gave mercurius biniod. 3x and belladonna 3 in alternation.

July 3.—Throat less swollen, and temperature normal, pulse 98. Tonsils meet, and the inner side of each and the uvula are covered with exudation.

July 4.—Had no sleep last night, and membrane now has assumed the typical appearance of diphtheria. Swallowing very painful; speaks with difficulty. Ten c.cm. of serum injected, and medicines continued as before, and in addition a spray of peroxide of hydrogen; 9.30 P. M. the membrane had extended forward to the soft palate. A further injection of 10 c.cm., of serum was given.

July 5.—Next day, patient decidedly better, slept more than three hours; swallows with less pain, and voice has somewhat returned. The membrane has not extended, and appears to be detaching itself; portions of it have been coughed up.

July.—Slept four hours last night. Decidedly better.

July 9.—Much better. Membrane clearing away; only slight streaks can be seen on the uvulva and tonsils.

July 10.—Slept ten hours; better in every way; still aphonic, and fluids regurgitate through the nose at times. Paralysis of the legs followed; convalescence was hastened by change of air; ultimately the recovery was complete, and in every way satisfactory. This case gave great anxiety, from the evident extension of the membrane

down into the larynx and trachea, and at one time it seemed that tracheotomy would become necessary.

These two successful cases convinced me of the undoubted value of the serum, and I determined to use it earlier in my next case.

CASE III. Teddie B., aged seven, on July 30, 1896, had a temperature 103.2°, and there were two typical patches of diphtheritic membrane on the tonsils, and his breath was fetid. Within an hour I injected 8 c.cm. of antitoxin serum, giving still the biniodide of mercury. The day before he first complained of his throat, so that the injection was given on the second day of the disease.

July 31.—Membrane on each tonsil disappearing; only little spots were left on the side of the patches, which were so marked the day before. At 8.30 P. M. all traces of the membrane had disappeared.

August 1.—Pharynx normal, and seems quite well! Cured in two days.

CASE IV.—The last case which I intend to quote is very similar, only the patient, a little girl aged four, was a very delicate child, the victim of enlarged tonsils and post-nasal adenoids, and just such a case as would have done badly under the influence of diphtheria. I was fortunate in seeing this case also on the second day of the disease, November 18, 1896. Temperature was 106.6°, and there were patches of membrane on each tonsil. At 6 P. M. I injected 10 c.cm. of serum. Next day, November 19, the membrane had almost gone, and on November 20 completely gone, and the child taking food well. Thus both these cases were cured in two days!

Thus far I have only selected cases from my private Practice. Let us now turn our attention to the use of the serum in the London Homeopathic Hospital.

The homeopathic treatment of diphtheria having always been so much more successful than the treatment of the old school, it was only natural that the physicians of this hospital should be somewhat loth to relinquish a tried and proved method of treatment for something which was new A STATE OF THE PARTY OF THE PAR

and untried. And hence it was that the serum treatment was not used in this hospital until November 22, 1896, when I sent in Ellen Wheeler, aged twenty-one, under Dr. Moir's care, having the previous day seen her and injected the antitoxin serum. It was a remarkable case, the membrane being in the larynx and trachea, and the fauces entirely free. At a meeting of this Society some of you may remember I showed some portions of this membrane, which the patient coughed up.

When I first saw her she was in a most critical state, cyanosed, and coughing up long pieces of membrane, which to the naked eye resembled portions of tape-worm, at the imminent risk of suffocation. Improvement began with the use of the serum, and recovery was complete.

From this time the serum has been used in the hospital, although not entirely; and the following facts supplied by Dr. Bodman, who was house physician at the time, enable us to compare the results of treatment with serum and with homeopathic medication only.

During the year October, 1896, to October, 1897, thirty cases were treated in this hospital, with three deaths. these thirty, seventeen had antitoxin, and only one died, a mortality of 5.8 per cent.; and thirteen had no antitoxin, and two died, a mortality of 15.3 per cent. If we now turn to the statistics of the old school the results are even more strik-The most valuable paper on the subject has recently been published in the British Medical Journal (October 23. 97), by Charles Clubbe, who has charge of the diphtheria branch of the Sydney Children's Hospital. He has drawn his statistics from six hundred cases of diphtheria, all of which were under his own care, and it is this fact which makes them so valuable. Three hundred cases were treated without serum and three hundred with serum, the former with a death-rate of 52.7 per cent., the latter with a deathrate of 20 per cent.

An article on "The Treatment of Diphtheria," by Dr. George Peck, deserves a brief notice. A series of questions were sent out by Dr. Peck. Have you ever used antitoxin?

was one, and to this over 50 per cent. replied they had never used the serum; and of those who had only a very few appear to have been impressed with its value. It may be the serum used was defective or its virtue destroyed by the climate.

Within the last fortnight I was called to see a bad case of diphtheria in a child aged seven, in consultation with. Dr. Searson. On my first visit, on November 18, the treatment which Dr. Searson had employed appeared to have mastered the disease; and as there seemed no immediate danger, although it was a severe case, involving the naso-pharynx, we decided not to use the serum, but persevere with the local treatment; swabbing the fauces with a solution of perchloride of mercury, 1-4000 and giving internally the biniodide of mercury 3x.

On November 21 I was again asked to see the child. The membrane had not disappeared from the fauces, but would reappear some time after the swabbing had been left off. The child's condition was distinctly worse, and it was decided to use antitoxin. Six c.cm. (1500 units) were injected. This was the sixth day of the disease. The nasal discharge soon ceased after this, and the breath became less offensive; the membrane persisted on the throat for two days longer, and then disappeared. A slight papular rash followed, and some aching in the joints. The patient is now, I believe, convalescing.

I have endeavored to set forth my experience of the use of the antitoxin serum, and since I have used it I have not lost a single case, although some have been of a severe type, like the first two cases I quoted, and Dr. Searson's case.

The statistics drawn from our own hospital cases, and those of the Sydney Children's Hospital, are most convincing.

In Cases III. and IV., in which I injected on the second day of the disease, the patients were practically cured in two days. Even if the serum is injected in a case which is not diphtheria, no harm results. In one case of severe tonsilitis, with membranous exudation, I injected the serum, regarding the case to be diphtheria. A bacteriological examination, made from a portion of membrane taken at the time, revealed no Klebs-Loeffler bacilli.

The difficulty of diagnosis in diphtheria should always prompt us to avail ourselves of this bacteriological test. In another case, of a child aged 4½, admitted under my care in Barton Ward, the pseudo-bacilli were found, causing a non-virulent form of disease, but one which in another person might produce serious symptoms.

All the cases I have cited were proved to be true diphtheria by the bacteriological test.

These are the conclusions which I have come to from my experience with the serum, and I believe all who approach the subject with an unbiased mind will become as firm believers in its efficacy as I am myself.

ON THE GENERAL MEDICAL TREATMENT OF DIPHTHERIA.

BY BYRES MOIR, M. D.,
Physician to the London Homeopathic Hospital.

IT is interesting to notice the steady increase that has taken place in the number of cases of diphtheria treated in this hospital. When I was house surgeon, seventeen years ago, not more than one or two cases a year were admitted, while in the twelve months just finished thirty cases have been under treatment. Diphtheria and typhoid fever have changed places, for when I was resident we saw plenty of typhoid, whereas we now get only a few cases in the year.

Dr. Bodman has been drawing up tables for a paper for the next number of the *Hospital Reports*, and has kindly allowed me to make use of them. His figures show the same thing with regard to frequency of admission. He has taken 120 cases, and for this has had to go back to 1886.

In dividing these into four series of thirty cases, the first series of thirty were from 1886-91, a period of five years, while the next series were in two years, 1892-94, and the last thirty were during the twelve months of his residence in the hospital.

Along with the increase of the total number of cases during the last ten years, it is satisfactory to notice a continued diminution in the percentage of deaths—even before the use of antitoxin. The mortality in the Metropolitan Asylums Board Hospital has been steadily falling, from 59 per cent. in 1888 to 29.6 in 1894.

Our own cases are too few to draw any definite conclusions from, but in the first series of thirty cases the death rate was 33.3 per cent.; in the second, 30; and in the third, 26.6; while, in the last thirty cases treated in the hospital, thirteen without antitoxin, and seventeen with, there have been only three deaths, two of the cases being moribund on admission, thus giving the death-rate at 10 per cent.

In the hospital cases, which have been under Drs. Blackley, Clarke, Epps, and myself, the treatment has varied greatly, but a large proportion have received mercury in one form or the other, principally the cyanide or biniodide. The cyanide of mercury has a great reputation among homeopaths. In Dr. Arnold's interesting paper on the "Therapeutics of Diphtheria," read last year, he gave very striking figures of the success met with by different observers in the use of the cyanide. Dr. Villers was one of the first to report on its successful use, having used it in over 100 cases, with no deaths. Dr. Sellden of Sweden reported that in his district the mortality which in four years, 1879-82, had been 92.7, was reduced by the use of cyanide, internally and also as a gargle, so that 1400 cases gave a mortality of 4.9 per cent.

We have not met with the same success; whether it is due to having a different class of cases or not I cannot say. Nearly all our cases have been under ten years of age, and in nearly all the fatal ones the nasal and laryngeal regions have been attacked before admission. I have no doubt in my own mind of the great value of the mercury salts, especially when the treatment is begun early, but I cannot look upon them as specific.

For mild cases, where the septic condition is not well marked, we have good remedies in kali bichromicum, phytolacca, bromine, and ammonia, but they do not meet the blood-poisoning; and we naturally turn to lachesis, crotalus, and apis, all of which have rendered me good service. They are of the nature of toxins, and I think much light has been thrown upon their action by Dr. Johnstone's paper on "Serum-therapy"; and I do not think we have been making the best use of them that we might. When there is present the marked blood-poisoning which we so often see, it must be difficult to stimulate the vital powers to react against the diphtheria poison, and I think a more rapid and better action would be obtained by administering them hypodermically. In Dr. Hayward's monograph on "Crotalus," he brings forward several cases of malignant scarlet fever, where little or no action was obtained by administering crotalus by the mouth, but immediate benefit was obtained by applying it to a blistered surface; and I think we are to be blamed for not having followed the lead which he gave us.

Dr. Day has dealt with the subject of antitoxin, so I will only add that, from my own observation of the cases which have been treated with it, it gives far better results than we can get with any of the other drugs I have mentioned, and I have been struck with its action even when given in a late stage. The first case in which I saw it used was a boy who was admitted with laryngeal diphtheria, and Dr. Bodman had to do tracheotomy at once; the patient went on fairly for a day or two and then the wound became covered with membrane, and almost as a last hope antitoxin was administered, though I did not think it a fair test on account of the stage of the illness—but in twenty-four hours he showed decided improvement, and made a steady recovery.

The question of local treatment is a very important one, and I consider that, even with antitoxin, it should be persevered with steadily. I used to have no fear of cases when we got them at an early stage and could apply local treatment to the parts affected—as a rule they all did well; but it was quite a different thing in cases where the nasal fossæ were implicated, and fatal cases nearly always came from these. In children, it is impossible to properly irrigate the nose, and the danger is a steady progress in the toxemic condition.

The fetor of the breath is a very important sign with regard to the progress of the case, and I always feel easy as soon as it is overcome.

The local applications can be roughly divided into two classes—as disinfectants, or from their action as solvents on the membrane.

Among the first I must put most reliance on insufflation of flowers of sulphur and gargling with Condy's Fluid. Each person has his own favorites, and there are plenty to choose from-alcohol, petroleum, chlorate of potash, corrosive sublimate, etc., etc.

As solvents of the membrane I have certainly seen benefit from papain, and lime water, either painted on with a brush or as a spray.

As soon as there are signs of decided interference with the respiration tracheotomy should be done without delay, the success of the operation depending very much upon its being done early and not waiting for serious symptoms; our results in the hospital have been very satisfactory. On the Continent and in America, since the use of antitoxin, intubation seems to have come greatly into favor; but so far we have not used it, except in one case of mine where Mr. Wright tried it.

After the direct dangers from the membrane are over, many cases are fatal from the sequelæ, and here I think our homeopathic treatment gives us great advantage.

The sequelæ usually met with are: nephritis, pneumonia or broncho-pneumonia, and the different forms of paralysis.

In the nephritis we have sheet anchors in cantharis, terebinth, apis, and arsenicum; in the pneumonia, kali bichrom., phosphorus, and antimonium tart.; while for paralysis, gelsemium, causticum, belladonna, and nux vomica.

I would wish particularly to draw attention to the use of belladonna in the paralysis of the respiration and heart.

Failure of the heart is met with in two conditions; first, in the early stage of the disease, when the heart itself seems to fail; and second, in the later stages when it is due to changes in the nerves, and it is in this condition that belladonna given in 1- or 2-drop doses of the φ tincture is of great value.

Discussion on the Papers of Drs. Roche, Day, and Moir.

MR. DUDLEY WRIGHT believed that to perform tracheotomy three cuts were sufficient; first, a longitudinal incision made deep down exposed the isthmus of the thyroid, and then a second transverse incision just above it divided the layer of fascia binding down the isthmus, and enabled the operator to push the isthmus of the thyroid down and reach the trachea; then a third cut in the trachea finished the operation. thought one almost always began by making too small an incision, and, blood welling up, the field of operation was hidden. When the trachea was opened there was no need to be in a hurry to put in the tube. It is essential to incise the trachea in the mid-line; by steadying it with the two fingers one could manage to hit it off fairly easily. As to feeding there was often a difficulty, and his experience was that children did not like to have the feeding tube passed through the nose, and he only did it as a last resource. He had found very great value from oxygen inhalations in the after-treatment. Mr. Wright then described the instruments used for intubation. He did not recommend anæsthetizing, as the amount of mucus which flowed when that was done was enormous. Opinions had changed very much in relation to this treatment since the introduction of antitoxin. Before that time the necessity of leaving the intubation tube in for several days, and other circumstances, militated against the convenience of the use of the tube, and, as a consequence, it was

only used with success in those cases which were the most hopeless for tracheotomy, namely, very young children. Nowadays there was no question whatever that the antitoxin treatment had altered the form of operative treatment very considerably, and they might possibly look forward to an era of greater usefulness for the instrument he had described. The most suitable cases for that condition were those of the ordinary type, which were only moderately severe. Dr. Klein, who had had very considerable experience in Berlin in the Kaiser Kinderkrankenhaus, had treated a large number of cases of diphtheria since 1893. that year the antitoxin was not used, and he had had thirty-seven cases intubated, nine of which were cured—24 per cent. 1894 he intubated, without serum, eighty-seven cases, and with serum, sixty-eight. The percentage of cures for the intubation without serum was 20 per cent., not so good as the previous year; but with antitoxin it was 54 per cent., much more than double the percentage of cures without its use. In 1895 the percentage went up still higher. All his cases were treated with serum; they were all intubated, and 65 per cent. were cured. He thought that was a very good percentage indeed, as compared with ordinary tracheotomy. Dr. Klein also remarked that since the introduction of serum the number of cases requiring surgical treatment had been much less, either tracheotomy or intubation; and again that, in the earlier cases before the antitoxin treatment, tracheotomy was very often needed after intubation as a secondary operation, but since the introduction of the antitoxin treatment, he had had very few such cases. It was always advisable, however, to have tracheotomy intruments ready when performing intubation.

DR. MADDEN said it was interesting to note that the first reference to diphtheria in homeopathic literature was in a paper by Dr. Francis Black, written for the British Journal of Homeopathy in 1858. At that time it was a new disease in this country. It had apparently only been introduced some two years before, and was known by the name of Boulogne throat. Dr. Black had given reports of cases which had been treated by himself and his colleagues, and it would be found that the lines of treatment and the medicines used were very much the same as at the present day-a striking proof of the continuity of ideas in homeopathic practice. At that time, however, the cyanide of mercury was not

The first knowledge of it was gained from Dr. Beck in He, as the result of experiments, without any idea of its being used from the homeopathic standpoint, found that it produced an exact simillimum of the whole disease of diphtheria. It produced congestion, ulceration of the tonsils and pharynx, and indeed, a very fair imitation of the diphtheritic membrane, besides its general toxemia. They had also the striking results of treatment both by Dr. Villers of St. Petersburg, who treated all his cases with high dilutions, and by Dr. Sellden of Sweden, who treated his cases allopathically with material doses. treated one hundred cases with a mortality of nil; Dr. Sellden and his colleagues treated fourteen hundred cases with a mortality of under 5 per cent. They could not expect anything better than that from such a virulent disease as diphtheria. though the iodides of mercury produced inflammation and ulceration of the throat, they did not produce nearly such a picture of diphtheria as the cyanide. It was a curious thing, which he should like to hear explained, that the greatest successes had been found by those who used it in high dilutions and material Those who used it in the medium doses did not meet with the same success as those at either end. Dr. Stonham had written a paper in the Monthly Homeopathic Review, 1889, in which he reported five or six cases rapidly cured with the 30th. Dr. Goldsbrough, somewhere about 1884, had read a paper in which he brought forward exactly the same result. Dr. Goldsbrough had been disappointed with the results of 3x and the 3d, but in the 6th and the highest he had good results. All the good results he [Dr. Madden] had obtained had been from the 6th and the highest. It was most peculiar and unaccountable how various were the statistics of the different treatments. been told of the treatment from an allopathic source with an average of about 50 per cent. of deaths, or higher, where they had not used serum. Many years ago they had accounts of the use of perchloride of iron as the local application, with a mortality of 1 in 73. There were also statistics—he was quoting from Dr. Arnold's most interesting paper—of the local application of paraffin, where there were 122 cases, with 2 deaths. Dr. Martin had written to the Lancet with regard to the use of sulphate of magnesia, which he had employed in over fifty cases with a mortality of nil. Why was it, if those experimenters could

get such splendid results from simple local applications, that men of the greatest experience, having everything at their command for the application of those methods, could produce nothing approaching it? He could not understand it, except on the supposition that the epidemics were of a totally different class of the complaint—that the one set of cases were malignant and the They could not accuse those men of mistaking other simple. the milder forms of sore throat for diphtheria. With reference to the local applications he would ask Dr. Blackley if he still used the preparation which he spoke very highly of some eight and nine years ago-viz., bromoform-as an inhalation. Dr. Blackley had then spoken very hopefully of its use, and had quoted one or two cases where it had been successful. Everybody seemed to admit that the serum was an additional help, and however good results they might be able to obtain with homeopathy, unless they could produce the result of a complete cure in every case, he thought it was not only permissible but right that they should adopt serum as well as the homeopathic treatment.

Dr. Hughes thought that if homeopathic treatment were carried out with the biniodide of mercury, homeopathy was not done justice to. The mercurial action in this compound was very small in comparison with that of the iodine, and iodine in ordinary diphtheria had no action whatever. He knew it was traditional, and he wished to speak with all respect of those who used it; but he ventured to think that if they would reconsider it and watch its action they would see that it was utterly futile in real diphtheria. With regard to the Sydney statistics, which Dr. Day had made great use of, he would call attention to the enormous mortality in cases not treated with serum. When they put 20 per cent. side by side with 52 per cent. it did look like a grand gain. But how came the 52 per cent.? Must there not have been some injurious treatment in those cases? And might it not have been the leaving off of that treatment which had a great deal to do with the fall in mortality? He would illustrate that by reminding them of Mr. Lennox Browne's statistics. Just as, in the present instance, 300 cases had been taken before serum and 300 after, Mr. Lennox Browne took 100 cases before serum and 100 after, and found that the mortality was nearly identical. But what was that mortality? Fifty-two? Twenty? No; it was twenty-six; so that the Sydney man lost double the number of his cases treated without antitoxin as compared with the cases treated in the London hospital from which Mr. Lennox Browne got his statistics. He thought if this point (and there were many more statistics pointing the same way) were taken into consideration, it would be found that they had not gained so very much by the use of antitoxin as was sometimes supposed.

DR. GALLEY BLACKLEY said he occasionally used bromoform as an inhalation in laryngeal cases; but in the pharyngeal form of diphtheria, especially in fetid diphtheria, he had come to the conclusion that it was not a sufficiently powerful parasiticide or antiseptic. It did not destroy the fetor and did not prevent the growth of membrane. In some laryngeal cases he still used it and thought it was an excellent inhalation. It was an anæsthetic, and the children were quieted by it. He generally used 20 or 30 drops every three or four hours, and after tracheotomy he had found it very useful. He did not look upon the statistics brought forward by Mr. Lennox Browne as so infallibly correct as Dr. Hughes did. He thought there could be no resisting the enormous mass of evidence now existing in favor of the decreased death rate under antitoxin treatment, even to homeopaths who had had an opportunity of treating large numbers of cases by cyanide of mercury, the biniodide, and the serpent poisons. had had nothing like the success of those gentlemen in Sweden who had 1400 cases with almost no deaths at all. He had seen a few cases treated by antitoxin; all were very severe cases, and all got well. With reference to the local treatment, he had been recently treating a case of putrid sore throat of a very severe form, and he had used formalin as an application in a diluted form. It was not a pleasant application, but was most efficacious and cleaned the throat up in a wonderfully short time. He was going to use the powder of formalin in gelatin as an insufflation in the next suitable case.

DR. CARFRAE considered that they had never tested the use of the animal poisons by injection as they ought to do, and thought they would turn out to be extremely valuable by being subcutaneously injected instead of being given through the mouth.

DR. DYCE BROWN said, with regard to Dr. Day's cases, it was a pity they had the two treatments mixed, as they could not judge what part each treatment played. In the last few years he had seen very few cases of diphtheria, but the medicines he

had found most useful were the cyanide and biniodide of mercury, chiefly the former.

DR. EPPS said that some of the cases quoted in the statistics had been under his care. When the serum treatment was begun in the hospital he was opposed to it, but they had had three or four most severe cases which had got well by it, as well as, if not better than, by other modes of treatment. At his [Dr. Epps'] suggestion the serum method had been tried alone, without homeopathic treatment, and had proved most successful. With regard to the homeopathic treatment, there was no remedy equal to cyanide of mercury in the sixth and higher dilutions.

DR. SEARSON said that one of the difficulties of judging of the comparative value of the antitoxin treatment was that of having no fixed factor to go by in the treatment of bygone days. practitioners had been in the habit of using local applications and some had not. Some had used one method of medical treatment and some another. He thought the only fair way to judge the antitoxin treatment would be to compare it with some other fixed method of treatment. Apart from the fact that the antitoxin treatment seemed a somewhat filthy curative agent, it was to be remembered that, while they were conscious of the proximate benefits, the remote results had yet to be ascertained. Again, from the standpoint of the general practitioner, there was a difficulty, as anything injurious which might take place afterward would be attributed by the parents of the children to the new. and to some of them unknown, treatment. In the cases of diphtheria which he had had to treat during the past five or six years, his custom was to swab the throat thoroughly with a solution of perchloride of mercury, first at a strength of 1-500, and afterward at a weaker strength indicated by circumstances. He was glad to say he had not lost a single case. The point he wished to emphasize was that antitoxim was still on its trial and had not been fairly compared with other successful methods of treatment. At the same time he would consider its use indicated where the membrane had invaded the larynx, also in the cases of young and nervous children; in all cases, in short, where local treatment was either difficult or impossible.

DR. BODMAN emphasized the importance of performing the operation of tracheotomy early; that is, as soon as the retraction of the lower part of the chest becomes well-marked and persist-

The crucial point in the operation was how to deal with the isthmus of the thyroid. His experience was that each case must be judged on its merits. As to the use of the tracheal dilators, a very useful instrument was Parker's. trachea was opened the dilator was inserted. There was no need to be in a hurry to put in the tube. The first thing to do was to see if there was any loose membrane in the trachea, and if so, remove it. As to the tube used, Parker's tube in his opinion excelled all others; being specially designed so as to conform to the anatomical condition of the parts, and therefore more comfortable to the patient. With reference to intubation, one difficulty was that tube might be coughed out, and therefore in private practice, where there was no skilled assistant at hand to replace it, the child might die before relief was afforded; therefore its practice was almost limited to hospitals, where medical aid could be summoned at once. There was more difficulty in feeding after intubation. When the antitoxin was injected early the membrane separated very rapidly, and therefore, if one got a case early and injected the antitoxin, intubation would probably be sufficient. With respect to the results of antitoxin treatment in the hospital during the past year, there were 17 cases treated with it with one death, a mortality of 5.8 per cent., and 13 cases treated without, with a mortality of two, or 15 per cent. There were certain facts connected with those cases which greatly emphasized the impression which they gave at first; in the first place the number of severe cases was very much greater in the group treated by antitoxin than in that in which it was not used. Secondly, the average age of the patients in the cases treated by antitoxin was very much less. Thirdly, the treatment with antitoxin was begun much later, on the average, than that of the cases where it was not used. Therefore, the antitoxin gave a mortality of little more than a third of that in cases not treated with it. although the cases were more severe, the patients younger, and the treatment was begun later. It was those accessory facts which gave the importance of the figures. No case which had antitoxin treatment subsequently required tracheotomy. Nothing was so convincing as to watch a malignant case of diphtheria recover after the injection of antitoxin. He had given about twenty-five injections of antitoxin, and had seen no bad effects. except the occurrence of a rash in about two cases. That was certainly not a sufficient reason for giving up the treatment.

DR. GOLDSBROUGH said it seemed to him that as homeopathic practitioners they had in the antitoxin a first aid in the treatment of diphtheria, and they ought to consider in every case whether it should be administered or not. The objections to its use would no doubt be got over by and by, when a greater knowledge of its after-effects were known.

MR. JOHNSTONE said that Dr. Searson had mentioned one of the common objections to the use of antitoxic serum, viz., that it was an unnatural thing to inject an animal substance into a human being. He would meet that by reminding them that they ate and drank serum in the form of meat and meat juice, and he did not see that there was much difference in injecting it under the skin. Moreover, the very latest ideas prevalent among the pioneers in serum-therapy were that the immediate effect of the injection of the antitoxic serum is not due to the antitoxin contained in it, but that there was introduced into the child a certain amount of serum, containing albuminoids and other matter, which acted as stimulant and nourishment, and gave the patient a temporary fillip over a dangerous crisis; that only after a little time did antitoxin begin to take effect, by neutralizing the toxic poison in the blood. With regard to the after-effects, such as rashes and nephritis, it was found that ordinary serum from an ox, sheep, or other animal would have almost the same effect: that in reality the injurious effects were probably not so much due to the antitoxin substance itself as to the materials normally contained in the serum. It might be that at some future time the chemist would be able to separate the true antitoxin from the serum, and produce the curative material in its pure state. Of its curative effects he did not think anyone would have any doubt whatever, if they looked carefully into all that has been written on the subject, or watched the results in practice, and so arrived at an unbiased conclusion. He thought the statistics were most convincing that the antitoxin treatment of diphtheria was at present better than any other treatment in use, and that, when combined with homeopathic treatment, the mortality was still lower.

Dr. Stonham said allusion had been made to the cases which he had published some time ago, treated by cyanide of mercury

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in the thirtieth dilution. There were nine successive cases occurring in two houses, and all had quickly recovered. The cyanide of mercury had also been very valuable in other cases, but it stopped short when the larynx was attacked. Directly the larynx was attacked it was of no further use. The only thing he did find of any use for the larynx in drug treatment was the vapor of acetic acid. He had seen really marked effects from the child inhaling vinegar vapor. All those cases had been treated before the days of antitoxin serum.

MR. KNOX-SHAW thought that everyone had his own particular weakness with regard to the tube used in tracheotomy. He liked to have a tube which he could hold, and preferred Hilton's tubes to any other. The point he wished to emphasize to physicians It seemed to him that in diphtheria they were endeavwas this. oring to carry their patient through a most serious condition of blood-poisoning. There was the toxin of diphtheria in the blood, and if they could bring the patient's blood into such a condition that it could resist and neutralize that toxin they would probably get him over his difficulty. The more he saw of bacteriological work in surgery the more he was convinced of this, that the greater the injury to the part, caused either by a severe operation or by bruising, the greater play the bacteria had in doing their deadly work. In diphtheria he thought they had the same thing going on as in ordinary surgery. If they got the slightest laryngeal obstruction, enough to keep the proper amount of oxygen from the blood, they were diminishing the resistance of the patient to the disease most enormously. On those grounds he should like to support Dr. Bodman's plea for an early operation. He knew the difficulty met with from the friends of the patient, but he believed most strongly that the success in the tracheotomies which Dr. Moir showed in his paper in the last number of the Hospital Reports was due to his great insistence on the point that if they were going to operate at all, it should be done long before the necessity becomes apparent to the friends of the patient, because at that period the operation was generally far too late.

DR. ROBERSON DAY, in reply, said he had had more experience with the biniodide than with the cyanide, but in future he would bear in mind Dr. Madden's advocacy of the latter. There was no doubt that the types of disease changed in succeeding ages, and it was never quite fair to draw comparisons between statistics

based on an epidemic in former years with one at present raging. That was why he placed such great reliance upon the statistics he quoted of the Sydney Children's Hospital. Dr. Dyce Brown objected to mixing the treatment, but he [Dr. Day] had great confidence in homeopathy and also in antitoxin, and therefore combined the two.

DR. ROCHE, in reply, wished to emphasize the use of sulphur, which he had used with glycerin. He found it was difficult to get sulphur well over the throat when the child struggled, but if glycerin were used with it one could be pretty sure one had gone over the whole surface.

APPLICATION OF THE FORCEPS.*

TRANSLATED BY B. F. UNDERWOOD, M. D.

(Continued from p. 64, January, 1898.)

A PPLICATION of the forceps upon the vertex arrested at the superior strait.

When, which is quite common, the superior strait of the pelvis is retracted in its antero-posterior diameter, the fetal head does not engage. It does not descend into the pelvis during the latter part of pregnancy, as is the case in the normal condition; at the end of the seventh month in primiparæ, in the course of the eighth month in multiparæ.

If, at the moment of labor, the uterine contractions are not strong enough to force the head into the pelvic basin, which is usually most readily accomplished, art should intervene. Basing our opinion upon the statistics of the Lariboisere Maternity and of the Baudelocque Clinic, we believe that, in these conditions, the forceps, properly applied, give to the infant a greater chance for life than version.

Necessarily, before seeking to learn how to apply and utilize the forceps, we should first study the position of the head which is to be seized, its relations with the retracted pelvian ring, and the mechanism by which it traverses the strait when labor occurs spontaneously. The fetal head, re-

^{.*} From the French of Professor Farabeuf and Dr Varnier.

tained at the slightly retracted superior strait, is in a transverse position; the occiput looking directly to the left or directly to the right, one parietal in front, the other backward.

It is ordinarily little flexed: the exploratory finger touches almost equally easily the frontal or the occipital fontanel.

As the normal position of the uterus is much less oblique than the axis of the superior strait, the axis of the head

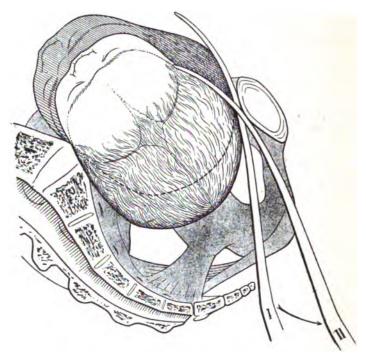


FIG. 96.

does not correspond to the axis of the strait. The head asynclitic, in transverse position, falls (the woman being upright) nearly perpendicularly upon the top of the pubis, although it touches the promontory behind; in such a way that the sagittal or interparietal suture, transversely turned, is immediately behind the anterior arc of the pelvis. The

anterior parietal slopes toward and overlaps the symphysis, and is for the most part inaccessible to the touch; the posterior parietal, on the contrary, occupies nearly all of the area of the superior strait, and can be reached and explored in all its extent as far as the lobe of the ear, which is situated six or seven centimeters above the sinciput, nearly to the height of the promontory of the sacrum. Fig. 96, dark head.

Fig. 96.—Vertex at the superior strait, flexion completed, occipital right transverse position. The dark head shows the initial position; the interior parietal sloping away from the pubis; grasped by one blade of the forceps, of which the handle I is strongly thrown toward the coccyx. The light head shows the position attained by the traction and movement, following the arrow, of the handle from I to II: engagement is produced owing to the depressibility of the posterior temple.

The presentation is therefore bad in a double sense; by the side and not flexed.

When the uterine contractions, which for the moment we will suppose to be efficacious, act upon the fetus, it will be seen that the presentation of the posterior parietal is at first accentuated, because the head, until now mobile, is fixed, upon the entrance of the strait, and begins its engagement. Little by little flexion of the head is produced. Examine the result: it rejects the ear of the side of the occiput, raises the temple, and brings this preauricular region, depressed and depressible, to the right of the promontory, where the ear was—the temporal and parietal relatively projecting and resistant. At the same time the parietal eminence, advancing to the position of the forehead, passes and stops a little beyond the median line. Fig. 97.

Fig. 97.—Vertex at the superior strait, in occipital right transverse position. The dark head shows the position before flexion; the light after. By the flexion, the parietal eminence is brought from P. to P¹, nearer to the corresponding side to the front; on the contrary, the ear (dotted) is carried to the side occupied by the occiput. The result is

the placing of the depressible temple in relation with the promontory, dotted line.

This flexion may be accompanied by a slight modification of the initial position of the occiput, which, in place of remaining exactly transverse, becomes slightly anterior. En résumé, the posterior temple is on the median posterior line, applied to the side of the promontory, while the anterior parietal eminence borders on the median anterior

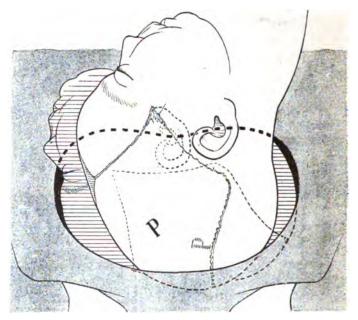


FIG. 97.

line and projects over the pubes. The posterior parietal eminence engaged some time before and is lower than the promontory, and can be felt behind, in the sacral concavity. If it is brought closer to this cavity, the sagittal suture is removed from the anterior pelvic arc, the anterior parietal is engaged, and in a short time its eminence alone remains above and behind the pubis.

The uterine contractions determine, little by little, this change of inclination of the head and compel the axis of

the cephalic ovoid, which at first was far from according with the axis of the excavation, to approach what is called the *synclitisme*. It is in this way, in experiments upon the manikin, that the pressure of the finger exerted upon the anterior parietal, or that of the forceps of Fig. 96, acts.

The engagement thus made is accomplished by the same mechanism. The cephalic diameter which suffers compression goes from the occipital version of the anterior parietal eminence, but slightly reducible and prominent, to the posterior temple, which is depressed by the promontory. In proportion to the amount of this depression, the parietal eminence descends and becomes engaged; then the head is inclosed, as Smellie, Levret, and Baudelocque expressed it; it appears to be able neither to advance or recede.

The anterior parietal eminence having passed the strait, the head abruptly falls upon the floor of the pelvis. Thus a head having a bi-parietal diameter of 9½ centimeters may pass through a sacro-pubic diameter of eight centimeters or even a little less.

When the uterine contractions are not able to produce this effect, it must be accomplished by the forceps. What is to be done? How is it to be done?

- 1. The head is in a bad position. It is necessary that this should be remedied by the instrument pressing the descendant pole backward until the center of the pole nearly corresponds with the pelvic axis; this is the work of the lever (Fig. 96) more than that of the forceps. But is not each separate blade of the forceps a lever? And if one obtains from the suppleness of the perineum and of the coccyx the possibility of introducing, of insinuating, a blade in front of the head, between it and the pubis, the handle which carries the blade will it not be a very powerful lever, with its point of support behind the pubis, pressing the head backward and even reducing it before the promontory? We will speak of this later (Fig. 105).
- 2. The head is insufficiently flexed. Consequently the parieto-malar, the only good and solid taking, since it is necessary to hold the head firmly, is impossible if the guid-

ing hand, in penetrating, does not induce beginning flexion, or if the forceps are not applied at first back of the ears, to determine the flexion, before making regular and definite seizure.

We have shown in the preceding chapter (Fig. 23), and following, that direct occipito-frontal seizure was proper only to prevent or correct flexion of the head.

We have already used the forceps, behind the ears of a head in indifferent position, to flex it, knowing that the instrument soon slips. As the menace of slipping is produced only when the flexion is already notable, we know, at the first warning, we should loosen the instrument, disarticulate, and remove it; and replace the blades, one after the other, in approaching the ideal taking. We are thus able, after replacing them many times, to accomplish the parieto-malar taking. It is evident that, in seizing the head by the sides, we leave it, particularly if we loosen the instrument from time to time, a certain liberty, analagous to that of a hen in its coop, of becoming flexed under the action of the uterine forces and even of its traction, without escaping from the blades of the instrument. It is necessary to remember that the contrary is true of the direct and oblique occipito-frontal seizures.

3. The head is too broad to pass. Therefore the reducing action of the instrument should be exercised in a biparietal sense and work for a retracted promonto-pubic diameter. An opposite result is obtained by an occipito-frontal seizure; that is to say, in placing one blade to the left of the mother and one to the right.

We do not think that anyone will object to what we have to say and that everyone will agree that the ideal movement is to place, relative to the maternal pelvis, one blade behind and the other in front. It is certain that to accomplish this placing of the blades is a little difficult. But is it not sufficient to decide the question in favor of the biparietal taking, that this taking is, in the great majority of cases, the only efficacious one?

Smellie and Baudelocque, two great authorities, do not

teach anything else; nevertheless Deleurye, the apostle of the easy but inefficacious, supports it.

How would those who still place the blades on each side of the mother seize the head when the time comes to solidly grasp it? By the forehead and occiput? No. It may be that the two blades become diagonal in spite of the accoucheur, for want of finding a place at the extremities of the transverse pelvic diameter obstructed by the occipito-frontal; it may be that, regularly placed on each side of the maternal pelvis, they become diagonal to the head at the outset of their pressure; an examination of the imprint has always demonstrated to Ramsbotham and to Simpson that the application of the forceps at the superior strait tends nearly always to an oblique taking. Nevertheless the oblique taking has always had its partisans, for the introduction of the blades is easy. The truth of this statement can be easily proven by experiment upon the manikin by operating, in the manner of the ancient partisans, with the forceps of Levret. Place the head in the occipital left transverse position, and grasp it in such a way that the concavities of the forceps are turned equally to the left but also forward toward the ilio-pectineal eminence; the posterior blade behind the left ear of the fetus, anterior blade on the frontal eminence and right external orbital apophyses of the fetus. This blade is not enough in front, relatively to the mother, to modify the vicious inclination of the head; but it is enough frontal to prevent useful flexion; both reduce uselessly the oblique cephalic diameter seized and unhappily increase the other.

If traction is made upon the forceps, you feel that the pelvian concavity tends to come in front, and, if it comes there, obliges the head to become diagonal, which presents the transverse cephalic to the grand pelvic diameter? The cephalic diameter reduced by the blade! What do you offer to the promonto-pubic diameter retracted? The cephalic diameter increased, since it is perpendicular to that which is compressed by the blades. With violent

traction, it happens sometimes that the head is engaged after the forehead is depressed by the promontory.

It is not astonishing, after these explanations, that so many accoucheurs of the present time should prefer podalic version to the forceps, when the head tends to become engaged in the superior strait, which, although retracted, is believed capable of allowing it to pass.

But version is much more perilous for the infant than the forceps, properly applied.

Since 1883 M. Pinard has succeeded in demonstrating that the regular taking of the head at the superior strait—that which places each blade on the parieto-malar meridian, the one before the promontory, the other behind the symphysis—is possible. His experience has demonstrated to him that it is less dangerous and more efficacious; it is the only one that we should describe.

The method of applying the forceps in the regular application of the instrument to the head at the superior strait is, with some modification of detail due to the height at which one is obliged to operate, the same as that of application to the head in the transverse position in the basin of the pelvis.

We will take as the type an occipital left transverse position; the head supposed to be lightly flexed. We will study the attitude of the head and its relations with the retracted pelvic ring.

It will be remembered: I. That the head should be grasped in the parieto-malar regions which are, the one posterior and below, the woman lying upon her back, resting upon the projecting promontory; the other anterior and high in the hypogastrium, above the pubis.

II. That the concavity of the blades, for the final extraction after the rotation to the inferior strait, should be turned toward the occiput, which will be brought under the symphysis. It is therefore necessary to introduce and place first, backward, the left (pivoted) blade, flat upon the promontory; introduce, following backward and to the right, the right (notched) blade, and to finally bring it in front, behind

and above the pubis, by the grand spiral movement of three times 45°.

APPLICATION OF THE FORCEPS.

First blade, the left pivoted—guided by the right hand—held in the left hand.

Introduction of the guiding hand. The entire right hand, thumb included, fully vaselined, will be introduced in the vagina, in a supine position; the dorsum turned directly backward. It will come in contact with the dilatable neck of the uterus; dilated, but not to the maximum, and will pass it without difficulty, and will touch and examine the head and will glide directly backward, between the posterior parietal and the sacrum. To go higher, above the strait, which is indispensable, the ends of the fingers should raise the head, and submit to the painful pressure on the promontory. At this price only can they reach and cover the ear as far as the lobule, that is to the height of the cheek.

The hand, embracing in the palm all of the side of the head turned backward, should easily, in curving beneath the occiput, complete flexion. The endeavor should be made to avoid compressing the umbilical cord.

Finally, the guiding hand being properly applied upon the posterior parieto-malar line of the flexed head, the introduction and proper placing of the left blade are assured.

Presentation, introduction, and placing of the blade. With the left hand the handle of the blade is held high up and is directed, obliquely, to the left of the median maternal plane, turned toward the right hand. Rest the beak flat upon the palmar surface of the right wrist, which is within the vulvar ring and of which the back strongly depresses the fourchette, that the axis of the blade may be well in, like that of the guiding hand, the median antero-posterior plane. Lower then the left hand and the handle which it holds, slowly and directly, avoiding particularly an approach to the median plane; lower it considerably, until its handle touches the guiding forearm. You will feel the

blade, of which the convex face should never quit the palm of the right guiding hand, rise in this palm, reaching and finally passing the promontory.

Any attention that you have given to keep your guiding forearm very low, will prevent the lowering of the neck of the blade, without which the penetration will be insufficient. Retire therefore the guiding hand, continuing to lower the handle and to keep it under the left hip. The blade, swallowed, so to speak, will disappear behind the head; the penetration will not be arrested; the blade will be in position only when the pivot is at the fourchette.

Having reached this position the blade should be held immovable, by an intelligent and attentive aid, who, kneeling at the left, should not on any consideration allow the least alteration or modification of the position.

Remark the attitude well. The handle of the left branch placed is already notably lowered, and depresses the posterior commissure of the vulva. It is naturally thrown under the left thigh; the more as the head is less thoroughly flexed. The hook will be turned directly upward.

Thus the first blade will be properly placed. It will serve as an index for the placing of the second blade.

Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

A TEXT-BOOK OF GYNECOLOGY. By JAMES C. WOOD, A. M., M. D., Professor of Gynecology in the Cleveland Homeopathic Medical College: Fellow of the British Gynecological Society; etc., etc. Second Edition, Revised and Enlarged. Philadelphia: Boericke & Tafel, 1898.

Professor Wood's text-book is so well and so favorably known that an extended notice of the work is apparently needless, although the revision and enlargement have been so great as to make it practically a new book; to a greater or less extent every chapter and almost every page has been rewritten. Much new matter has been added, so that the work is fully up to date and an authoritative exposition of the subject; adding one more to the list of homeopathic works which compare more than favorably with the best allopathic works.

The chapter upon electricity, in view of the importance which this method of treatment has obtained, has been entirely rewritten and clearly and concisely gives the indications for and methods of using this powerful auxiliary, but while this and other methods have been fully described, the great merit of the work is that it is thoroughly homeopathic, and the homeopathic treatment of diseased conditions is always advocated and the indications for the appropriate remedy succinctly given.

The number of illustrative cases has been greatly increased, which adds much to the value of the book for the general practitioner.

Many new illustrations have been added, making two hundred and ninety-five illustrations in the text and thirty-seven colored and half-tone plates, the most of them from the author's practice. The book is finely printed, attractively bound, and a credit alike to the author and publisher.

Malgrin Medien.

Berberis Vulgaris in Enuresis.—Dr. Waldran, S. Jour. of Hom.—Sticking, cutting pain from kidney to bladder and ureter; a sensation as if not emptied.

Aloes in Summer Diarrhea of Children.—Dr. Gaston, Med. Coun.—Aloes has yellow stool, jelly-like, watery or windy with intense colicky pain in lower abdomen, associated with extreme prostration with constant sensation of insecurity of the sphincter ani—the rectum feels full of fluid.

Bryonia in Scarlet Fever.—Dr. Fisher.—Bryonia, although not often indicated in the early stage, is yet appropriate to those characterized by slow development of the rash. There will be the throbbing headache aggravated by cough, nausea, or motion of any character. Because of the absence of prompt development of the eruption meningeal symptoms are early manifest. When these are coincident with high fever, flushed face, dry throat, etc., belladonna may be the remedy. Or, symptoms arising from meningeal complications may be so acute and sthenic as to call promptly for aconite. But, when arising from non-development of the rash, bryonia does excellent service and should not be overlooked.

Corallium rubrum in Whooping Cough.—Dr. Dewey, Med. Cent.—This is a very useful remedy in severe cases of whooping cough. Before the cough there is a smothering sensation. The child gasps and gasps and becomes black in the face. It is the remedy for that short, quick, ringing cough known as the "minute gun" cough. The smothering shows itself in the form of gasping, crowing inspirations. After each attack of cough the child sinks back perfectly exhausted. It is perhaps oftener indicated in the later stages of the affection, but the neurotic element must be present, and also the constriction of the chest before the attacks. The crowing inspiration or whoop is not so pronounced as under mephitis. Dr. Teste recommended corallium and cuprum as prophylactics of whooping cough, and Dunham praises corallium in violent cases.

Graphites in Leucorrhoea.—Dr. Ward.—Weakness of the back coexists with very liquid, perfectly white discharge, often

associated with a papulous itching eruption of the external genitals and distended abdomen. The discharge gushes out when rising in the morning or squatting. Sixth decimal trituration morning and evening for six days, then discontinue for six days, then commence again.

Rhus Tox. in Hemorrhages.—Bright-red blood, aggravation of the symptoms from chagrin or the least emotion; disposition to be angry; uneasy and timid mood; tickling in the chest.

Mygale in Chorea.—Dr. Nunos, Hom. de Mexico.—The choreic movements are angular—continual movement of the eyelids—vertebral column is sensitive to the touch; itching of the eyelids and different parts of the body.

Millefolium in Hemorrhage.—Millefolium is an excellent remedy in hemorrhages. The blood is bright red, similar in appearance to aconite, but lacking the anxiety of that remedy. In menstruation too profuse, the flow is bright red and partly clotted; in hæmoptysis the flow is also bright red, but there is no fever when this drug is indicated.

Ustilago in Uterine Hemorrhage.—Dr. Lardinois.—Belgian Jour. of Hom.—Ustilago resembles ergot in its action, producing contraction of the arterial capillaries. Uterine hemorrhages from atony, the flow being sometimes red and at other times dark and coagulated. Post-partum hemorrhages or from the presence of a fibroid. Sometimes these tumors disappear under the action of the medicine. Uterine hemorrhages with pains extending to the knees.

Senecio in Disorders of Menstruation.—Dr. Fothergill, Med. Chron., reports his personal observations with senecio in disorders of menstruation. He used a tincture of senecio Jacobea, I-10; also, a I-1 aqueous and alcoholic extract of the same plant; also a dried extract. The doses used were one to two drains of the tincture, twenty to thirty minims of the fluid extract of the dried product. Three or four doses were given daily. He found that senecio does not cause abortion, but will cure most cases of functional amenorrhæa. In cases of anæmia, and other conditions of exhaustion due to disease, the drug was found to have little effect. It proved useful in certain cases of dysmenorrhea, but the relief was uncertain. In six healthy married women the administration of the drug caused the flow to appear from three to nine days before it was expected.

Calcarea Phos. in Rachitis.—Dr. Raue.—Not less important than carbonica; its principal indications are the fontanels, which remain wide open, the diarrhea, and the emaciation of the child. Both the calc. carb. and phos. have been administered in large, crude doses with far less good results than in a fine homeopathic preparation.

Veratrum Viride in Croup.—Dr. Searle, Hahn.—Veratrum viride is more valuable in croup than all other drugs combined. A few drops of the tincture in water, frequent teaspoonful doses during the night, and less frequent ones during the day, quickly and certainly dispose of all forms of croup except the membranous, and even in that control both fever and spasm, thereby aiding kali bich. and other remedies.

Rhus Toxicodendron in Scarlatina.—Dr. Nimier.—Zeitschrift des Berlin. Vereines Hom. Aerzte.—Recommends rhus tox. in scarlet fever when there are prostration, delirium, swelling of the throat, especially on the left side, with reddish discoloration of the skin in that region, red and smooth tongue, and somnolence. If the disease be complicated with parotiditis, then the drug is still more indicated. To differentiate it from apis, which has the same symptoms with rhus, the eruption is much more intense and darker red, and there is actual excitement of body, and not continual restlessness, as with apis. In the associated parotiditis it frequently precedes lachesis, chiefly when the inflammation is not pronounced, in the beginning and before the purple redness appears. It is also indicated when the scarlatinous eruption makes its appearance with difficulty.

Veratrum Viride in Pyo-Septicæmia.—Dr. François Cartier, L'Art Médical, recommends veratrum viride in infections with great oscillations of temperature, as in pyo-septicæmia, manifesting itself in the many different ways, as puerperal fever, cellulitis, erysipelatous phlegmons, pelvic suppurative processes, etc., as has been demonstrated, especially in later years by the German and French writers. These oscillations of temperature indicate most frequently an acute septicæmia, and are almost always dependent on the streptococcus. He employed the tincture in doses of 4 to 6 drops a day. It is wholly different from aconite in its action. The snake-poisons, tarantula cubensis, hepar, mercurius, and myristica are its analogues, but none of them have the characteristic "jumps" in the temperature.

Cubebs in Leucorrhoes.—Dr. Allen.—Yellow, greenish, acrid, offensive, with pruritus and intense sexual desire.

Natrum Sulph. in Infantile Diarrhea.—Dr. Ealer.—Natrum sulph. 6x is called for in chronic diarrhea in children, where even slight injuries to the skin cause long-lasting inflammation and suppuration, especially if they are located around the root of the nails.

Belladonna in Mammary Abscess.—Dr. Richardson, St. Louis Journal of Homeopathy.—When the breasts feel heavy, are very hard, and the redness runs in radii, accompanied with pulsating pains, high fever, headache over the eyes, constipation, scanty urine.

Chamomilla in Threatened Abortion.—Dr. Danforth.—Threatened abortion, with discharge of dark blood; frequent urination, urine profuse and pale; great restlessness and agony; irritability; heaviness of whole abdomen; frequent yawning, chills, and shuddering.

Lachesis in Albuminuria of Pregnancy.—Dr. Christine.— This remedy is indicated in dropsical conditions associated with albuminuria, where cedematous tissues are disposed to be dark colored. The urine is dark and albuminous, and sometimes nearly black. The symptoms are aggravated after sleep.

Peroxide of Hydrogen in the Ophthalmia of Infancy.—In the milder forms of conjunctivitis which are so apt to occur in infants soon after birth, one part of Marchand's Peroxide of Hydrogen to fifty parts sterilized water and dropped a few drops into the eye, every four hours until the eye is well, is effective.

Zincum in Ovarian Pains.—Dr. Arkell, Hahn.—Boring pain in left ovary, better from pressure and during menses, but return at their expiration. Menses early and too profuse. Despondent, pale face. Sexual mania from pruritus of vulva. Pains in small of back, worse sitting or standing. Cannot keep feet still; fidgety. Distention of abdomen before menstruation.

Cocculus Indicus in Backache.—Cocculus has a good deal of pain in the back, as if the menses were coming on, with drawing, lacerating, boring pains; sensitiveness of the spine to touch; pains worse on walking and stooping. The symptoms of this remedy are more often found in light-haired women who are of a changeable, hypochrondriacal humor, and sensitive to insults, slights and disappointments.

Kreasotum in Dysmenorrhea.—Dr. Dahlke.—During the post-menstrual flow there is a certain pain, which becomes decidedly aggravated as soon as the flow ceases entirely.

Iodium in Spasm of the Glottis.—Dr. Stifft.—Iodium 6x with calc. phos. 3x; of the first a few grains every second day twice, and of the second drug the same quantity of the trit. every evening. In the case of an infant of seven and a half months, three days after beginning treatment there was a very violent attack, and thence on they gradually decreased in severity, so that in two months it had wholly disappeared. He cites Baehr to the effect that he prefers it to all other remedies in spasms of the glottis.

Kali Bichrom. in Membranous Croup.—Dr. Newberry, Medical Era.—As to internal medication, kali bich stands at the head of the list. He has used it in a low potency in several cases with excellent results. One case in a boy of eight years, with almost complete occlusion of the larynx, yielded to the administration of kali bich. internally and permanganate of potash locally. No other remedies were administered, and the child made a speedy recovery.

Hydrastis and Ergotin, Action of, Upon the Uterus.—Dr. Fellner.—As a result of careful experiments has arrived at the following conclusions:

- 1. Hydrastis canadensis as well as ergotin produces marked uterine contraction after its intravenous or subcutaneous injection.
- 2. The effect is direct; that is, it is not caused indirectly by its influence upon the vessels.
- 3. Contractions after ergotin are more powerful than those after hydrastis, and follow each other more rapidly; they are of longer duration, and of tetanic character, while the contractions caused by hydrastis are always separated by periods of relaxation, especially after repeated doses.
- 4. Both drugs after repeated use of large doses, and especially after intravenous use, lead to a paretic condition of the uterine muscle—more rapidly with hydrastis than with ergotin.
- 5. Both preparations increase the blood pressure and the heart's action, and the uterine contraction may occur with either a diminution or an increase of blood pressure.

Xanthoxylum Fraxineum²⁰ in Dysmenorrhea.—Dr. Deschere,
—Menstrual pain before and after flow. The pains start in the

hypogastrium, and shoot down the thighs. Sick headache, with nausea and vomiting. The menses are profuse and always late. but preceded and followed by a milky leucorrhoea. The blood is offensive. The patient is of a very hysterical and hyperæsthetic nature. Pathogenetic Symptoms: Menses profuse and too early. Cutting pains, sudden pains in right ovarian region, extending down thigh and passing over to left side. Leucorrhœa white, milky, after menses. Shooting from region of right ovary to hip, thigh, and back, with gushing, milk-white leucorrhœa, ceasing suddenly. During menses, which are too early and painful, cramp-like pain in head and abdomen; hungry, but food nauseated, when vomiting the stomach felt as if rising and falling. Clinical Symptoms: Neuralgic dysmenorrhea, pains going down the anterior portion of the thigh, mostly left side. Neuralgic dysmenorrhea, with neuralgic headaches. Remarks: A powder every night and morning, to begin two weeks before menstruation is The next period set in prematurely, at the time when the leucorrhoea used to appear, but painless. There was still headache, but the blood was not offensive. The prescription was re-The following periods were normal. Headache only occasionally, but no more vomiting.

Cynecological Pląhings.

Ovulation and Menstruation.—Dr. Cook, who was with the Peary expedition, says the Eskimo girls do not begin menstruating until they are eighteen or twenty years of age. It has, however, been stated that they conceive and bear children at a much earlier age, a fact which has been adduced to show that there is no necessary connection between ovulation and menstruation.

Hemoglobin and the Red and White Blood Corpuscles in Pregnancy and the Puerperal Period.—Dr. Wild has observed a slight increase of hemoglobin and of the number of the red corpuscles and a very considerable increase of the white corpuscles, as compared with the red, in the last weeks of pregnancy. A diminution of the hemoglobin and the red corpuscles—the latter in much smaller proportion—follows labor, and is to be at-

tributed to the physiological loss of blood. The slighter diminution of the red corpuscles is to be attributed to their new formation. Both constituents of the blood increase again in the puerperal period. The number of the white corpuscles reaches its highest period soon after labor, and diminishes again in the puerperal state. Nursing has a favorable effect on the regeneration of blood.

Origin of Gelatiniform Cysts of the Placenta.—Dr. Delore, L'Obstét, in connection with a research on the maternal circulation in the placenta, advances a new explanation of the mode of origin of gelatiniform cysts on the fetal surface of the placenta. He believes that the jelly of Wharton exists not only in the umbilical cord, but also in the placenta, and especially in the choricallantoidian layer. Retention of this jelly, by such an accidental obliteration as happens in sebaceous cysts, leads to the formation of the gelatiniform placental cyst. If such a cyst be incised it can be seen that it is an accidental cavity, produced by a glueing together of the villi by fibrin and a separation of the chorionic membrane.

Missed Abortion. - Dr. König, Vratch, reports a clinical case of fetal retention or missed abortion, the English term being introduced. The patient was aged thirty-three; she had gone through six normal deliveries (the last three years ago) and one The abnormal pregnancy continued for eleven months. During the fifth and sixth months there was discharge of blood. This returned in the course of the last three months. The general health was good. The uterus lay four fingers' breadth above the pelvis, and did not contract during exploration; the vaginal portion of the cervix remained firm. externum, however, was patulous, admitting the forefinger, by which a spongy mass could be detected. Ergotin and hydrastis being given, the patient on the next day discharged the ovum, which measured 4.3 by 21 inches. It exhibited numerous hemorrhagic foci, but the original cause could not be ascertained. König also writes of a woman, aged forty-two, who sustained severe mental shock at the sixth month. Uterine pains set in and the movements of the fetus ceased. Three months later it was expelled; it had lain dead in the uterus for all that time without causing any disturbance. He further reports 27 cases published since 1835, 10 having been observed in Russia.

majority of patients were multiparæ aged between thirty and forty; all the primiparæ were elderly. In 29 per cent, the nine months of pregnancy were exceeded before expulsion of the ovum. In only 2 cases is it related that the placenta continued to grow after the death of the fetus.

Rise of Temperature in Childbed. - Dr. Bumm, Centralb. f. Gynak, reports that although a new building and perfected antiseptic precautions have been at the disposal of the patients in the Basel University maternity, the results have not come up to expectation. Bad sepsis has not been observed, but high temperatures were noted in 170 out of 750 labors. He tabulates them thus: 27, or 16 per cent., of the patients were feverish through diseases complicating labor-phthisis, pneumonia, etc.; 95, or 55 per cent., suffered from direct infection of the genito-urinary tract or breast—namely, 22 (13 per cent.), through streptococcus infection: 1 through colon bacillus infection: 11 (7 per cent.) through gonorrhea; 58 (or 35 per cent.) through putrid intoxication, and 3 (or 0.4 per cent.) through phlegmonous mastitis. There remained 48 (or 29 per cent.) where no cause of infection could be accurately determined. He dwells on the small percentage of infections from micro-organisms, and the mild and purely local character of the symptoms when such infection did occur. In 58 (or 35 per cent.) of the cases it was clear that retention of secretion in the uterus, wherever that secretion was infected, accounted for the rise of temperature.

Diagnosis of Sex of Fetus.—Dr. Keefe, N. E. Med. Jour., as a result of his observations in over one hundred cases of sex in generation, formulates the following rules for prognosticating the sex of an expected child:

- 1. When both father and mother are matured, that is, over twenty, if the vigor of the husband is relatively greater than the wife's, expect a female child.
- 2. When with all other conditions the same as in the first, only that the mother is relatively more vigorous than the father, expect a boy.
- 3. When the parents are relatively of equal vigor, expect an equal division of the children as to sex, for nature seeks the conservatism of the species by equal division of the sexes. If, however, with the vigor the same, the complexion of the mother is dark and the father light, you may rather expect a boy. If, on

the other hand, the father is dark and the mother of light complexion, rather lean toward a girl.

4. When one of the parents, although apparently as vigorous as the other, but is comparatively either immature or senile, consider the one nearest the age of stalwart maturity as the more vigorous. For example: A wife sixteen to eighteen, or forty-two or over, with a husband twenty-five to forty, prognosticate a daughter. On the other hand, with a husband sixteen to twenty, or forty-eight or over, and a wife twenty to thirty-five, expect a male child.

Very many exceptions to these rules will occur, so many, indeed, as sometimes to make them appear of doubtful application. Nevertheless a patient and extended trial will prove their utility.

Cancer and the Menopause.—Dr. Ill, Med. Record.—It is the duty of those who have family practice to give women some idea of the innocent symptoms accompanying the menopause; to teach them that the menopause means a cessation of the flow, not an increase, and to insist on an immediate examination if anything occurs which is not plainly and solely attributable to this condition. It will be better to err on the wrong side and make too many examinations. Nowadays women rarely object when the matter is properly placed before them. I would, however, strongly disapprove of frightening the patient into an examination by threatening her with the word cancer. With that word one can get a woman to consent to almost anything.

He gives the following as the chief symptoms of change of life:

Complete cessation of the flow, which is somewhat sore; more commonly called irregularity in the periods. The flow usually becomes more scanty; rarely is it at times increased. When this occurs, a pathological state of the endometrium is usually present.

Nervous symptoms are the rule.

The symptoms of cancer of the uterus he gives as follows, stating, however, at the outset, that there are none characteristic of this disease:

In a woman of middle life, excessive flow without local or general cause.

Constant serous or sero-sanguinolent discharges.

With either of these symptoms examination should be insisted upon. Under no circumstances should we wait for cachexia or a discharge having a foul odor, since to do so often means waiting until the disease has reached an unoperable stage.

The Tampon in Local Treatment.—Dr. Searle, Hahn.—The tampon is one of the most important means of local treatment. It can be made of sterilized absorbent cotton or lamb's wool; the latter is preferred when a non-absorbent material is desired. It is light, very elastic, and serves as an excellent temporary support for displacements of the uterus. Absorbent cotton tampons become heavy and, at times, irritating to the patient. When a tampon is used only for support, it should be covered with carbolated vaseline, which assists in introducing it and renders it easier to remove.

The tampon should be carefully selected to fit and not overdistend the vagina. It is a good plan to make three or four sizes and select one according to the requirements of the case. The method employed is as follows: Cut from a roll of cotton a strip six inches wide; then cut this into smaller strips two inches wide by six inches long. One, two, or three of these smaller strips can be laid one upon the other until the desired thickness is obtained. This is nicked in the middle on both sides to the depth of onehalf inch, and a clean piece of cotton twine tied around it. The cotton is then folded on the long diameter, and we have a tampon two by three inches suspended by the twine at the end. Other smaller tampons can be made by cutting the small strips one and three-quarters inch by five inches.

Various medicinal substances are combined with glycerin for application on the tampon. Boracic acid, hydrastis, aristol, ichthyol, and tannic acid are among those most frequently used.

Boro-glyceride acts as an antiseptic—relieves pelvic congestion by the depleting action of the glycerin, which extracts water from the tissues.

Hydrastis is very useful in chronic gonorrheal vaginitis, endocervicitis, and erosion of the cervix, with profuse yellow and stringy leucorrhœa. It is best to use the colorless extract to avoid the almost indelible stain which the other produces. Twenty-five per cent. to fifty per cent. of the extract is mixed with glycerin.

Aristol is used in erosion of the cervix, specific vaginitis, and chancroid. It is suspended in glycerin, 3 j to f 3 j. It is also used as a powder.

Ichthyol has recently been used for erosion of the cervix and general pelvic soreness. It can be combined with glycerin, ten per cent. to twenty-five per cent.

Tannic acid may be applied as a powder or glycerole, its chief action lying in its astringent properties and thereby relieving relaxation of the vagina. Pulverized alum has a similar action in the same conditions. Both are useful for erosion of the cervix with profuse leucorrhœa.

Iodine (Churchill's tincture) is probably the application most frequently used. It is useful in cases of chronic metritis, subinvolution, and ovaritis of the subacute and chronic varieties.

Iodized phenol (one part carbolic acid to two parts Churchill's tincture of iodine) is used in about the same conditions that iodine is used; also in erosion of the cervix and endocervicitis. When used upon the endometrium for subinvolution and chronic metritis it should be diluted with an equal portion of glycerin.

Chromic acid, used in the strength 3j to f \(\frac{3} \) j water, has been recommended in cases of endocervicitis with stringy, albuminous discharge. This treatment should be reserved for those cases which do not yield to the milder applications, and should not be used oftener than once a week.

Obstehrits.

Diagnosis of the Location of the Placental Attachment by External Palpation.—Dr. Triboudani, Gaz. degli Osped., has been studying this subject at the clinica obstetrica of Pavia, examining the uterus of patients immediately after the expulsion of the fetus, to confirm his diagnosis made from external palpation beforehand. He announces as the result of his experience that the location of the placental attachment can be accurately determined by the following indications:

- r. It is attached to the posterior wall if the tube and round ligaments are found on the anterior surface of the uterus, converging toward the top; if the anterior surface is rather flat, and if the beat of the fetal heart, the parts of the fetus and its movements, can be distinctly distinguished from the front.
- 2. It is attached to the front wall if the tubes and round ligaments are found on the sides of the uterus parallel to its vesical

axis; if the anterior wall is very convex, and the fetal heart and movements and the fetus itself are easily distinguished from the front.

- 3. When the placenta is attached to the fundus the latter is remarkably convex, almost hemispheric, and the points of attachment of the tubes and ligaments are much below its edge.
- 4. When the placenta is attached to the side wall the uterus is very prominent on that side, and the attachment of the uterine adnexa are found much higher on that side.

Albuminuria and Nephritis in Pregnancy.—Dr. Allbutt believes that the opinion that the renal complications of pregnancy are due merely to mechanical pressure is erroneous. In the first place, he claims that pressure by the enlarged uterus upon the renal veins is not readily produced; again, complete thrombosis of the renal veins is not followed by renal symptoms which are averted by collateral circulation.

Moreover, swelling of the legs and other signs of venous obstruction are more frequent as pregnancies increase in number, whereas albuminuria and eclampsia are evils of the primipara.

Again, other large tumors, as fibroids, do not produce serious kidney disorders, though disturbances of micturition and even pressure of the ureters, followed by dilatation of these tubes, and even by pyelitis, may occur.

In pregnancy there is little evidence of serious pressure on the ureters, and dilatation of these tubes is rarely a complication. The puerperal kidney differs from the cardiac kidney, in that it is not as hard, is often pale, and presents signs of acute degenerative charges penetrating its tissue. It would seem that two poisons at least are concerned in the production, the one leading to convulsions, the other to coma. In some not infrequent cases the two acting together produce convulsions, followed by coma. It is now generally conceded that there is a toxin as yet unseparated in healthy urine. It is not urea, uric acid, kreatinin, or potassium chloride. Thudicum thinks it lies in the coloring matters of the urine. Allbutt thinks it most probable that the toxin is absorbed from the bowel, for it is less in amount in a fasting animal, in hibernation, and in the urine after sleep. point of formation of the toxin is also unknown, but it is probable that the liver is at fault, as is suggested by the frequency of liver disease in pregnant women. Saft believes that the condition is caused by an auto-intoxication by some product of tissue change,

as is the origin of molimina gravidatis, and of the nervous disturbances of the pregnant state.

It is a matter of great importance that the pregnant woman should learn to procure for herself daily evacuations of the bowels, especially toward the end of pregnancy and beginning of labor. Mild dietetic regimen will usually procure this; if it fails, mild aperients, as cascara, senna, or comp. licorice powder may be used.

It is of the very greatest importance during pregnancy and the puerperal state that the function of the kidneys be maintained, with a proper equilibrium between skin digestion, waste, and these organs. If any organ can bear a greater exercise of function it is the skin, and next in order of tolerance is the intestinal tract; the lungs are far more sensitive, and the kidneys most of all. If possible, no puerperal woman should be permitted to leave her bed until her urine is free from of albumin.

Mynlieff insists that when a women with chronic nephritis becomes pregnant the induction of abortion is indicated on account of the immediate peril of the patient (which increases as pregnancy advances), the certain continuance of the morbid process in the kidneys themselves, the great tendency of flooding and abortion, and the small prospect of the development of the fetus to term.

Dysmenorrhea.—William Watts, M. D., Toledo, O.—Correspondence.—I am pleased to add my commendation to the three divisions of dysmenorrhea as divided by Dr. Kent Sanders. Varieties in plenty are found, but three divisions are enough. One point is omitted, to which I would call attention, viz., a woman may have a severe attack of pain in the ovarian region during the intermenstrual period—no flow; simply the pain, lasting either a few hours or a couple of days. This recurs habitually, and is really an ovarian dysmenorrhea caused by the discharge of a Graafian vesicle. Still, there is no outward manifestation of menstruation, yet a slight amount of blood is discharged into the abdominal cavity. The pain is caused by the hardening of the ovary, or perhaps a better expression would be, by a toughening of the tissues and membrane covering the ovary, requiring greater force for the Graafian vesicle to reach the surface and be discharged.

Night Terrors.—Dr. Braun, Der Kinderarzt, after critically discussing the existing theories on pavor nocturnus in children, declares it to be a disease by itself, which is closely allied to the conception of neurasthenia, i. e., "an irritable weakness." Following this, a description of the characteristics of the attack and their demonstration is given. The sudden jumping up of the infant out of its sleep—symptomatic especially in colic—has no relation to night terrors. The ætiology, as well as the treatment, is that of neurasthenia, and the latter should be pointed in the direction of nutrition and education.

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BACKWARD DISPLACEMENTS OF THE UTERUS.

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Read before the American Institute of Homeopathy, June, 1898.

Retroversion of the uterus implies permanent dislocation backward with the axis of the body and the axis of the cervix essentially identical. Retroflexion denotes the permanent backward dislocation of the fundus, the cervix remaining in situ or participating in retroversion, the axes of the two parts forming an angle. In rare combinations retroversion with anteflexion or anteversion with retroflexion may coexist. The degree of backward dislocation is always a matter of relativity, and with the woman in the upright position is greater as the axis approaches the horizontal. Retroversion and retroflexion have intimate relationship, the former being usually a transitory condition originating the latter. It must not be understood that every retroflexion has retroversion as an antecedent, but that it is very frequently the case and that the two conditions have common causation. Practically they are found to coexist in many cases and must receive conjoint consideration. Whether it be retroversion, retroflexion or retroversio-flexio, matters little so far as etiology and principles of treatment are concerned.

Uterine position has wide latitude within normal limits. Situated between organs subject to distension and collapse, the uterus may be pushed forward or backward through a space of several inches as the frequent daily needs require. It may rise and fall to an equal or greater extent as is shown by sneezing, tenesmus, the genupectoral position and respiration. Its lateral mobility, while not so great, is yet marked and rotary motion is in some degree possible. Having no solid foundation upon which to rest, and being suspended in midpelvis by guy ropes and attachments more or less elastic, it may disport itself as a trapeze performer in executing any movement within its physical capabilities. Whether it rise or fall, lie prone or decubitus, traverse with its fundus an anteroposterior arc of sixty degrees, or make obeisance in its flexions to any point of the compass, is of small consequence so long as it shows its ability to regain and maintain itself. The positions assumed may be regarded even as anomalous, but so long as the uterus is able to return spontaneously to its normal position after the transient cause of the deviation has ceased to operate, it cannot be charged with displacement.

Uterine displacement cannot be diagnosed in the clinical sense until the deviation from the normal has become more or less stable. There must be limitation of automatic movement, prolonged departure from normal position and inability to maintain that position when regained to fulfill the requirement. In displacement passive movement may be in no sense circumscribed, the uterus may remain even abnormally movable, but active and independent exercise is more or less suspended, self adjustment is impeded and normal ability thwarted.

Uterine displacement, therefore, implies the embarrassment or obstruction of definite normal movement and the suspension in part or whole of normal ability. The play of forces incident to normal exercise has been disturbed and the equipoise lost. Natural prowess no longer obtains, an enervated and toneless organ is encountered and forces rule that dominate all passive bodies—I mean particularly the force of gravity. Especially is this true of all backward displacements of the uterus inasmuch as the consideration must embrace not only the weight of the helpless decubitus uterus, but the superimposed bowels pressing down upon its anterior surface, instead of forward upon its dorsum as in the normal position.

Backward displacement may be evoked primarily by any cause which may induce intensification of intra-abdominal pressure. Lifting a heavy object, violent vomiting, prolonged coughing, a blow on the abdomen or a fall in which the sacrum receives the impact, may serve as the initial. Even an habitually distended bladder may impinge upon the uterus so continuously as to engender permanent displacement. But while incidents of this character may serve as direct cause, there is in each instance a predisposing cause or antecedent condition of the system that must be regarded as part of the problem, Incidents capable of serving as the cause direct are of daily occurrence in the life of every woman, but it is only in cases of enfeebled or crippled vitality that they prove effective. When the life forces are regnant, uterine ligaments-contractile tissues—like the drawn bow of the archer spring back the moment the pull is relinquished, obliterating all evidence of displacement. It is only in cases of mal-nutrition and enfeeblement that elasticity is impaired, that power to regain the erect is wanting and that the uterus continues to lie after it has fallen.

It is clear that a comprehensive grasp of the subject cannot be gained without considering the antecedent factors potent in the production of this anomaly. Rigid induction has disproven the opinion held for a long time by most gynecologists that the predisposing causes of retro-displacements in the majority of instances were chargeable to puerperal experiences; that inasmuch as most victims of the misfortune are found among those who have borne children, the causation was, therefore, due to some mal-performance during the puerperal state. Careful clinical study has shown that while the larger quota of such patients are thus found among post-parturients, the pelvic weakness and liability to displacement, if not the dis-

placement itself, was in evidence before the first pregnancy, and the deviation was established or re-established in the puerperium because the uterine attachments were in the beginning relaxed.

This is in accordance with the observation of Kustner, that uterine displacements, or the tendencies thereto, "have been carried over into the sexual life from the time of puberty and puerility;" and proves that errors of development underlie most, if not all, of the cases, and that malnutrition is the universal factor. While the argument in no sense belittles the agency and importance of the puerperal factor, it justly emphasizes the necessity of the early and full development of the female sexual organs. The partial or complete arrest of the development of the uterus and adnexa is present in our day to a most surprising extent. The number of girls who reach the age of twenty with sexual organs in an infantile or dwarfed state is alarmingly great. Whether this be due in our cramming educational process to the diversion of the nutrient bloodsupply from the pelvic organs to a precociously developed brain: to the metastatic influences of zymotic diseases during puberty; or to indiscretions due to ignorance or wilful disregard of menstrual demands, I cannot now discuss. I note the fact as a reason for more rigid censorship over those girls, especially who are contemplating marriage, and over all who in any way manifest sexual embarrassment or inability, or who give evidences of sympathetic disturbances. thought on this subject demands that all girls shall be free from the handicap of sexual non-development before marriage is entered upon and whenever embarrassed functional evidences are announced. Motherhood should never be essayed by one possessed of organs wholly incapable of completing the act without extra hazard or catastrophe. Uteri and uterine attachments which ceased to grow at the age of thirteen or thereabouts, should not be allowed to attempt the responsibilities which are safely and easily discharged by organs of full maturity. To this effect there must be a recast of views upon the subject of early physical examination in all such cases. Invalid and markedly undeveloped girls must undergo the rigid scrutiny demanded in all such instances. They must be

the recipients of such remedial help as is afforded by the gynecological resources now developed. Their sexual help-lessness must be supplanted by that vigor and tone which is the birthright of every one and without which capability and the creditable discharge of normal function is an impossibility.

I have purposely dwelt upon this phase of the subject because I consider it to be the chief factor in the remedy of all utrine displacements. I mean (1), that the establishment and possession of such vigorous organic ability would be an effectual bar to the development and continuance of such forms of incompetency before the advent of child-bearing; (2), that it would insure freedom from most of the perils of parturition evidenced by the well-known train of sequelæ, and, (3), that no cure of uterine malposition can be attained without regainment of normal vitality—both local and general. Wisely directed treatment, therefore, must in the first place anticipate the effects of the force of gravity upon a helpless organ by insuring the proper development of that organ; it must by prophylaxis hedge against the possibility of uterine and adnexal disability; it must see to it that every young woman is possessed of her full complement of life-energy, both local and general. I say the work of the gynecologist properly begins before the announcement of uterine instability; and is, ideally, of the order of prevention rather than patchwork.

Unfortunately this wise exercise of our knowledge is too rarely permitted. The faulty practice now is to wait till the weakness is engendered; to withhold help till mal-position has become stable. It is the up-hill work of reform; it is the regainment and re-establishment of energy lost that is, for the most part, called for in these days.

Coming from the abstract to the concrete, let us enter the clinical arena and deal with conditions rather than theories. Here is a girl under twenty, who is complaining of menstrual irregularities. The menstrual discharge is wanting; is too scanty of profuse, or is voided with great pain. She is, perhaps, constipated, a poor eater and has bad digestion. She has neurasthenia and faints away with or without provocation. She may be a consumer of slate pencils, chalk, plaster or other earthy matter, and is more or less incompetent mentally as

well as physically. A reasonable course of medication. calisthenics, reform of school duties and, perhaps, residence in health resorts, has been tried without permanent benefit. Before much time is squandered in fruitless effort of this kind she should be anesthetized and examination made of her clitoris. vagina, uterus, ovaries and rectum. Clitoral adhesions should be broken up, stenoses of sphincters overcome, papillæ of urethra, vagina or rectum removed, as well as every other occasion of sympathetic irritation. The diminutive uterus—displaced or not-must have rapid and thorough dilitation; the endometrium freed from all traces of vegetation, and the uterine muscle aroused from its dormancy by the induction of "mock labor." This should be accomplished by means of uterine packing with aseptic gauze continued through several hours or until nature makes protest in a slight rise of temperature, say from one to three degrees. The object accomplished by this latter step is the quickened and enlarged circulation of uterine vessels and a consequent better nutrient blood-supply to the starved part. Of course the treatment by divulsion and packing must be dependent upon the absence of acute inflammatory conditions in uterus and adnexa as well as all other contraindications. But her sexual forces must be freed from all thralldom and aroused to energy by methods simulating the normal and mature exercise. Such an embarrassed girl, I say, should never be allowed to reach conception or be forced to acquire uterine development after a possible impregnation.

It is remarkable how responsive nature is to such effort particularly through the first half of the child-bearing cycle. Development and growth of retarded female sexual organs is attainable in most cases at any age under thirty years, and while increase to normal standards at a later period is more problematical or wholly impossible, the removal of all occasion of sympathetic irritability is followed by such physical calm as is compatible with good health.

Whenever retro-displacements have been acquired in the nulliparous state regardless of age, the foregoing regime is applicable, subject always to such modifications as may be dictated by the morbid conditions present in the given case. Inflammations within and around the uterus should be over-

come, resultant adhesions absorbed or loosened up and tubal or ovarian degenerations ruled out before the employment of the radical measures here outlined. It must be remembered that a long decline of vital energy may have preceded your effort at cure; that uterine ligaments may have been under tension in such degree and for such time as to have acquired undue length and wholly to have lost elastic tone, and that a long directed effort may be called for in the re-acquirement of health conditions. To this end there must be persistent employment of the properly selected internal remedy; the uterus must be kept in right position for a sufficient time by wool tampon or other properly adjusted mechanical support, and every adjuvant utilized that will favor this accomplishment. Even then it may be ascertained that the elastic tone is irreclaimable, the ligaments and connective tissues are persistently lax and elongated, and that surgical shortening may be necessary.

Whenever retro-displacement has been acquired by the woman after parturition, the requirements of treatment are in many respects identical with those found necessary with the nulliparous, but may have in addition many new features. While the development of the puerile uterus has been accomplished in a measure by means of gestation, the parturient act has been inadequately performed and extensions and additional burdens have been imposed upon the state of pre-existent weakness. Cervical laceration, retained placental fragment or endo-metritis may have thwarted the performance of involution, and subinvolution of the uterus and its ligaments may have remained. In addition, the vaginal and perineal supports may have been weakened or swept away by rupture, thus obliterating all the restraint and sustained force of the pelvic floor. Under such circumstances the abnormally heavy uterus inadequately tethered by its lax and subinvoluted ligaments, like a top-heavy balloon, falls helpless and enters upon its course of descent. Prolapse is next in order and full procidentia a matter only of time. It is good fortune, indeed, if, in all this embarrassment, sepsis has not been superimposed and the ravages of inflammation are not an additional complication; or, if the cell-life in uterus or ovaries has not been

diverted in its embarrassed activity into the evolution of cyst or fibroid, or other exhibition of hampered life exercise. In any event successful treatment is dependent upon the fullest comprehension of the facts and the probable employment of a wide range of remedial measures. The sole object being to establish or re-establish normal life ability all factors acting as a hindrance to this accomplishment must have abatement. Subinvolution, cicatrices, broken vaginal or perineal supports, perimetric or adnexal adhesions and all adnexal diseases or degenerations must be proven not to exist, if stability of normal uterine position is to be maintained.

Coincident with all this and of equal import with it in the etiological process, is the rectal factor. All gynecology must be a failure in greater or less degree that does not comprehend rectal pathology. Uterine morbidity, almost without exception, is attended by rectal morbidity. They go hand in hand, always a pair of them, and the ability to exhaust the general life force and make the individual affected a physical bankrupt, is as pronounced in the one case as in the other, and very effective when working together. It is sympathetic nervous irritation in both cases and the phenomena are identical so far as expression and significance are concerned.

From personal observation I am convinced that rectal morbidity is the leader of the procession in point of time; that it may, and usually does, originate in babyhood or early childhood, and that its enervating effects are operative long before the first impulses to quickened life are perceptible in the female sexual organs. Consequently I do not hesitate to believe that rectal morbidity plays a very large part in the causation of sexual non-development as well as in the production and continuation of the neurasthenia so pronounced in every gynecological case.

But after all has been done to rectify retro-displacements of the uterus that the nutritional problem can suggest, many persistent and wholly intractable cases will remain. The normal tone of uterine muscle and ligaments in such cases is irreclaimable by any and every kind of procedure. The uterus persists in resuming the decubitus whenever external support is withdrawn; or protests with pain and intolerance to the employment of any mechanical device or scaffolding, designed for its support. These are the cases that have tested the resources of gynecology to the utmost limit and have defied successful treatment till times the most recent.

To meet such emergency the operations of Alexander and Schroeder were introduced. In the one case the slack of the ligaments is overcome by the excision of enough of the ligaments to make them sufficiently short; in the other, the utility of the ligaments is disregarded by making the fundus uteri fast to the anterior abdominal wall. It is almost a double decade since the introduction of these measures to the profession, and from that day to this experiences have been ripening with great rapidity. Some advocate almost the exclusive use of the one or the other procedure, but the consensus of opinion is to the effect that each operation has a definite field not encroaching upon the other, and that they can be combined to advantage as occasion demands. Alexander's operation consists in opening the inguinal canal on either side of the pubes, picking up the round ligaments of the uterus, drawing them out as far as they will come readily, cutting off the surplus and fixing the ligamentary stumps in the inguinal canal. By this procedure the fundus uteri is approximated more or less to the anterior abdominal wall; the uterine body is lifted out of the pelvis and the retro-displacement is converted into anteversion. This operation is applicable only when absolute mobility of the uterus and appendages is assured, and when the latter are in an entirely healthy condition. Many operators have experienced great difficulty in being able always to find the round ligaments, and it has been proven that these ligaments are in anatomical fault sometimes in making deflections in their attachments to Poupart's ligament, or other tissues, rather than to the inguinal ring. In other instances the ligaments have proven too frail to bear the pull made upon them and have broken, thus defeating the endeavor; while in yet other instances hernia has been left as a legacy of bad technique. The great merit of the operation consists in the simplicity of its performance in the average case, and in the avoidance of entering the peritoneal cavity. The results in properly selected cases are most gratifying, the uterus retaining its regained position with greater tenacity than antecedently, or than under average conditions, and this notwithstanding the effects of following pregnancies. The field of this operation, however, as originally proposed, is greatly circumscribed by the fact that retrodeviations without adnexal lesions are rare, and that the correction of the former without overcoming the latter is sure to end in dissatisfaction to all. It has been proven that apparent mobility of a uterus retrodisplaced does not disprove the presence of embarrassing adhesions when the uterus is carried forward, and that such mobility does not imply freedom from adnexal disease. Persistent painful retrodeviation proves at once the existence of limited mobility as well as adnexal disease. Ovarian prolapse and ovarian degeneration have long been regarded as synonymous terms—the chronically prolapsed ovary being invariably degenerated.

Inasmuch, therefore, as the reposition of the uterus to its normal position without removal also of the adnexal lesions is followed so frequently by incomplete cure, open exploration of the pelvic cavity is frequently necessary. After the manual liberation of adhesions and the reclamation of diseased appendages by conservative surgery, or their ablation, if degenerate beyond redemption, the uterus by the ventral operation is fixed to abdominal wall by permanent sutures. The manifest advantage of this operation consists in the acquirement of exact knowledge concerning the intrapelvic condition by ocular demonstration and the opportunity to deal with the abnormality present, as the condition demands. The object of the operation is not merely to secure the adhesion of the fundus to the abdominal wall, but to see to it that all conditions capable of aborting the success of the procedure are overcome. The success attending ventro-fixation, hysterorrhaphy or hysteropexy, as the operation of Schroeder is indiscriminately called, has been of a very high order. Under certain contingencies ventro-fixation cannot be supplanted by any other procedure. The objections to the operations, however, are: that it involves the performance of coeliotomy and the dangers incident thereto; that the fixation thus made of the uterine fundus is an embarrassment in case of pregnancy, abortion thereafter being a frequent result, and that the aperture left by the operation between uterus and bladder is another opportunity for intestinal strangulation. While the validity of the first objection has been robbed almost of its force by the perfection of surgical tecnique, it cannot be denied that pregnancy has suffered interruption by the enforced impairment of uterine mobility, and that wayward intestines have migrated through and been caught in the foramen of Schroeder. For these reasons the trend of opinion is away from the practice of uterine immobilization, especially during possibility of childbearing; or, at best, that it must be an operation of second choice.

Modifications of the Alexander operation have been made that overcome the objections to its employment in the exceptional cases, as follows: After abdominal section and the removal of adhesions and the correction of adnexal abnormalities, the round ligaments are shortened by doubling each upon itself and stitching it thus doubled to the anterior wall of the abdomen or uterus. The resultant adhesions, while insuring permanent shortening, add greatly to the strength of the ligaments and the permanency of the results. In case of rupture of the ligament in the primary method of Alexander, or the inability of the operator to find the ligaments the suprapubic route and the intrapelvic method of shortening is justifiable.

In greater favor, however, is the approach to the pelvic peritoneum by way of vaginal section. The ease with which adhesions can be broken up and the success attending minor surgery of adnexa through vaginal section makes the latter the route of election in perhaps the majority of instances. Opening is made into the peritoneum either through the vesicouterine fold, or the recto-uterine fold, and ample proof gained as to the exact condition. Existent adhesions can be broken up; morbid or wholly degenerate adnexa can be patched or removed and frequently the round ligaments can be doubled upon themselves, as before described, leaving nothing to be remedied. Or if ligamentary shortening be not thus satisfactorily attainable per vaginam, the hindrances to the successful performance of an original Alexander's operation can be removed. The minimum risk to the patient thus gained, together with the feasibility and success of the procedure in a very large percentage of the cases in which Alexander's operation would otherwise be excluded, make the latter operation as amended the operation most widely applicable at the present time.

The endeavors to secure anteflexion in retrodisplacements by means of various operations to secure wider and firmer utero-vesical attachment have proven impracticable and therefore unpopular. Of this order was the operation of Schucking, which consisted in entering the peritoneal cavity between uterus and bladder, carrying a silk thread through the uterine canal and fundus and back through the peritoneal opening into the vagina, and then tying the ends of the thread so as to enforce anteflexion till the formation of adhesions. rodt's operation is based on a similar mechanical principle, but differs in its execution. Opening is made to the peritoneum through the anterior vaginal pouch—as in Schucking's operation—the bladder pushed up, the fundus brought down into the aperture made by the section and held there by strong stitches passed through the vaginal walls. In both operations an immobilized anteflected uterus is substituted for a uterus. having backward displacement, but more or less mobility. It has been proven to be ventrofixation by another route, and has occasioned abortion to pregnancy in like manner.

Yet other conditions may be present that will not be remedied by any of the foregoing procedures. Tears in the tissue of the fundus uteri during parturition amounting almost to rupture of that organ may be followed by cicatrices of equal importance to the more common expressions of that kind in the cervix; diminutive multiple fibroids may so occupy the uterine body as to defy successful conservative removal or the retrodeviation may prove to be an incident in the companion problem of procidentia. In all such cases uterine ablation may be the shortest road to cure—may be, in fact, the only road to cure.

An irredeemable or degenerate uterus either before or after climaxis is without efficiency from any standpoint of observation. Its day of usefulness being wholly past, its retention should not be tolerated, or certainly should not depend upon reasons of mere sentiment.

So long as uterine efficiency is reclaimable, effort should continue in the hope of attaining the desired result; but when failure has attended the fullest exhibition of gynecological resource, and a hypersensitive and hopelessly involved uterus acts as a drag upon the woman's existence, there should be no hesitation about amputation.

To recapitulate: Retroversion with allied conditions is dependent upon non-development primarily, and malnutrition secondarily, of the pelvic sexual organs, and is resultant from a more or less prolonged decline of local and general vitality. The onset of this decline and waste of vitality is due to causes which may be grouped in two grand divisions: First, those operative antecendently to and in conjunction with physical development, and second, those operative at the time of, and subsequent to, parturition. This classification, however, is purely arbitrary and must not obscure in any case the basal fact that malnutrition of uterus and adnexa is the gist of the whole matter. This is but another way of saying that inasmuch as the uterus with its adnexa is but an intmiate part of an organic union, the malnutrition must be general as well as special, and may be general before it is special. Whether, however, it is first general and then special, or vice versa, does not change the requisition that malnutrition must be banished and normal conditions of life be established. The hungry child must be fed; good blood in sufficient quantity—facilities of growth to full stature—must be provided, and the incubus of non-development banished in the local sense as well as in the general. In any event the essay of maternity should not be made except with organs mature and capable.

If, however, such blunder has been made and a train of parturient sequelæ results, the effort to banish malnutrition must still go on; the aim to remove the incubi to a vigorous blood circulation and to re-establish the tone of good health is still pressing. Polychrest remedies, both medical and surgical, may be called for and time almost without limit demanded in the acquisition. Even then failure to establish or restore never-possessed or lost energy may result, and the ablation of organs, that menace life, that render health acquirement impossible and that are in fact wholly worthless, be demanded.

After many years of patient endeavor to solve the problems of backward displacements of the uterus, I am convinced that the aggregate of gynecological knowledge may be required in the attainment of the desired object in all cases, and that the gynecologist capable of dealing with its many formulas must be master of his art.



AUTO-INFECTION.

BY HENRY EDWIN SPALDING, M.D., BOSTON.
Read before the American Institute of Homeopathy, June, 1898.

The knowledge gained during the last decade concerning sepsis, and the application of that knowledge to the discovery and use of means for attaining and maintaining asepsis, has very greatly lessened the dangers of parturition. This has been again and again proven by comparing voluminous statistics before the days of antiseptic proceedings with those of the last few years, when sepsis has been generally guarded against. These favorable results are shown not only in institutional but also in domiciliary practice. I will not detail them here, as to do so would be only rehearsing an old, oft-told tale. Such grand results must not for a moment be lost sight of, but it is quite possible that the intoxication of success may be leading the profession to ignore some factors in the problem that must be counted if its solution shall give, as a result, perfect asepsis.

Not long since, in a lecture before a society of Boston ladies devoted to the consideration of physiological subjects, a young physician, filled to overflowing with the latest lecture-room pabulum, made a statement like this: "With to-day's knowledge of sepsis and the use of antiseptics, the very simple fact that the patient has puerperal septicemia convicts the attending physician of ignorance or neglect in a degree that should disqualify him for the practice of medicine." Of course, such a broad statement had, for the moment, its intended effect, and each woman mentally condemned this or that previously esteemed physician to the shades of desuetude. The chances are that when that young man meets the stern realities of obstetrical experience, the scriptural rebuke, "By your words ye are condemned," will rudely awaken him to see the absurd self-assurance that led to their use.

In bringing before you the subject of auto-infection, I would not be understood as discrediting in the least the wonderful results attained by the careful and effective use of antiseptic measures. I believe they are of inestimable value and cannot be ignored in any degree. I would go steps farther. While guarding the citadel of vitality against the entrance of a foreign foe, I would closely scrutinize the forces within, lest they open the portals of the assailants, or themselves in concealed mutiny traitorously destroy it.

Since toxemia in parturition is subject to the same laws as toxemia in surgery, we may very properly look to surgical authorities and experiences for light in dealing with this subject. Roswell Park says: "One of the greatest advances made in recent pathology has been the establishment of the fact that a great many of the morbid conditions from which the human race suffers are those due to causes arising entirely from within their own systems." Again, "I have long maintained that many surgical patients present forms of blood poisoning in which the poison has not proceeded from the wound."

Indeed, Genzmer and Volkman have asserted that there is such a thing as an aseptic surgical fever, due to the absorbtion of the products of normal tissue changes at the site of injury.

Dr. E. S. Jackson says: "We cannot expect to classify the various types of puerperal fevers until we can classify the various causative bacteria." He insists that because the vagina contains these bacteria before labor, we must recognize auto-infection as one of the causes. Among the many others who recognize the fact of auto-infection are Barnes, in a recent paper before the British Medical Society; Henroty, Barton, C. Hirst and Lusk.

Within the limits prescribed to papers in this convention, it is impossible to do more than briefly mention some of the most conspicuous facts pertaining to the subject.

The intestinal tract may be the source of systemic infection from

- 1. Unexpelled normal excremetitious matters.
- 2. Ptomaines.
- 3. Pathogenic bacilli.

That fecal matter contains substances of marked toxic powers has been amply proven by practical observation, and experimental research has shown that excretive and other undefined substances that await investigation are highly toxic. The toxicity of putrid matter stands undoubted, and yet an extract made of putrid matter is much less toxic than one made of fecal matter. The products of liver action are in greater part

eliminated through the intestinal canal. By his liver man forms enough poison in eight hours to kill him. These substances unduly detained in the intestinal canal are taken up by the absorbents and produce systemic poisoning, which may be not only serious in itself, but so weakens the vitality that the resistance to the assaults of toxic germs that may find their way through some open door is ineffectual, and sapremia, septicemia, or even pyemia may result.

The more acute form of intestinal toxemia arising from ptomaines or leucomaines, violent in itself, destroys systemic resistance to attacks of pyogenetic and other bacilli.

What more interests us here is the fact that the intestinal canal, in its entire length, swarms with bacteria of various kinds, which, under favoring conditions, raid upon the interior of the body. A local injury or simple inflammation may furnish a lodging place for these wandering organisms and establish a focus of infective inflammation which shall result in a systemic toxemia. Park says: "The ease with which the colon bacillus passes through the coats of the intestine which has been in the slightest degree disturbed or abraded is remarkable." "Without the existence of recognizable lesions, these bacteria sometimes emigrate, and perhaps enter the circulation."

If this condition is an ever-present menace to successful results in general surgery, it must be much more so in parturition. Here the resisting powers are often weakened by disturbed renal hepatic functions; the blood is so changed by gestation that at other times the condition might be termed pathological; and then follows the still further devitalization from exhaustion incident to labor, and we have conditions most favorable to the invasion of toxic germs. Add to this an intestinal toxemia producing a condition of sapremia, as above demonstrated, and we have a condition most favorable for the working of pathogenetic bacilli. It needs only such a contusion or abrasion of the rectal surfaces as often attend difficult deliveries to invite a condition of fully developed septicemia or pyemia

Septic infection sometimes manifests itself before the onset of labor. I cannot better describe this condition than by briefly

reporting an illustrative case from my private practice. Mrs. ---- had passed through gestation in a perfectly normal manner, as she had done in two previous pregnancies. The day of expected delivery was at hand. For twenty-four hours there had been a free, bloody leucorrhea. She had no pains, and she seemed in perfect health. She was awakened during the night with a severe chill, intense headache, pains all over and nausea. Temperature immediately arose to 103.5°, pulse 120. The chill was followed by free perspiration, without, however, giving much relief. Her face was dark, congested and expressionless, except from the look of suffering. The least effort of moving or being moved increased her discomfort. In about twelve hours labor pains came on, and fortunately she had a quick delivery. She flowed freely, but not to a great excess. The child was robust, and a careful examination of the placenta showed no signs of degeneration or other abnormality. In two days the fever had practically gone, and she went through an uneventful recovery. In the absence of any renal or systemic disturbances, I believe that here was a case of sapremia, or possible septicemia, the bacilli having entered through the vaginal canal to the cervix, where the process of dilatation had caused a breach of continuity of surface, as indicated by the free bloody discharge during the previous hours.

Most modern bacteriologists, like Bumm and Boderlein, claim that auto-infection can develop nothing more than a condition of sapremia, and that pathogenetic cocci are not found in the healthy vagina or cervix. They acknowledge, however, that as soon as the normal healthy vaginal secretion becomes alkaline, which may easily happen from admixture with the cervical secretions, it becomes a most favorable culture medium for pyogenic staphylococci and streptococci, and auto-infection becomes possible. On the other hand, Mironow, with others, claims to have demonstrated the presence of streptococci and staphylococci in the vaginæ of healthy pregnant and puerperal women. When we remember that there are absolutely few healthy vaginæ, we must recognize the danger from this source.

Remy claims that the meconium is a source of puerperal in-

fection. If it became mixed with the liquor amnii, the uterine cavity will be soiled. This fluid decomposes rapidly. On the other hand, it is generally claimed that the meconium in the new-born child is free from bacteria, but rapidly becomes infected by them. This being the case, it is not the meconium that is the offending cause, but it offers a fertile soil for the growth of toxic germs.

The most frequent site of septic infection in the puerperium is doubtless the intra-uterine surface represented by the area of placental attachment. The uterine sinuses are plugged by thrombi, which, if the uterus be not firmly contracted, may extend well into the uterine musculosa. Thrombi are of themselves innocuous, and are cast away with other uterine detritus in the form of lochiæ. But let putrefaction take place from contact with pyogenic bacilli, by absorbtion we get a condition of sapremia, or the bacilli themselves with the decomposing clot may be taken from the sinuses into the circulation, giving complete septicemia or pyemia. The pyogenic cocci that thus infect the thrombi may come from the vagina, from some supperating disease, like cancer of the uterus or its appendages, and most frequently of all from a pus tube. In the absence of statistical proofs. I believe that 90 per cent of all cases of autoinfection come from this source, and that of all cases of puerperal septicemia, a large portion are infected in like manner.

When we consider how large a part of the work of gynecologists is the treatment of pyosalpinx, or troubles in which this forms a conspicuous part, we can readily comprehend the dangers from this source. The astounding statement is made that in New York city and France 80 per cent of the men have at some period of life been affected with gonorrhea, and 90 per cent so afflicted remain uncured; and of women who married these victims of gonorrhea, scarcely 10 per cent remained well. This means that many of these unfortunate wives go through the stages of vaginitis, cervicitis and endometritis, and the inflammation then enters the fallopian tubes and pyosalpinx results. If both tubes are involved, conception will not likely occur. If, however, but one tube is affected, conception is possible, and she is exposed to one of the greatest dangers of parturition.

DIETETICS IN OBSTETRIC PRACTICE.

C. A. WEIRICK, M.D., CHICAGO.

Read before the American Institute of Homeopathy, June, 1898.

Pregnancy is a normal condition. The development of the fœtus in utero, its birth, and the subsequent formation of milk in the mamma of the mother for its sustenance are physiological acts. It is a mistake to speak of the date of parturition as the time the woman will be sick. The maintenance of the health of the woman if she be well, its restoration if she be ill, and the highest development of the child are the objects sought from the physician. All treatment, including dietetic, is for the purpose of attaining them. Any diet that impairs the health of the mother or hinders the development of the child should be avoided. It would be superfluous to state such a self-evident truth were it not that a diet is recommended that has for its purpose the amelioration of the pain and shortening the duration of labor by preventing ossification of the bones of the head. An insufficient quantity of inorganic food will impair the nutrition of mother and fœtus. An excess of salts will derange digestion, but not promote ossification.

If during pregnancy the mother be in a normal condition the same kind of food that is proper for her when not pregnant should be given, if ill the same diet for similar affections occurring as at other times. For example, did albuminuria occur the proteids should be avoided or a minimum amount taken the same as were the woman not enciente. The woman's special attention should be called to the necessity of taking a sufficient quantity of water in twenty-four hours. The tendency is to take too little rather than too much. If she be a tea-drinker derangements of the digestive organs are more liable to occur than were she to abstain from it. If accustomed to this beverage, and it is not advisable to discontinue its use, black tea is preferable to the green variety. The custom of adding carbonate of soda to neutralize the effect of the tannin will, in some cases, neutralize the hydro-chloric

acid of the stomach to such a degree as to impair gastric digestion.

Several years ago in a paper read at the Illinois Homeopathic State Association, I called attention to two classes of mothers. As subsequent observations confirm those previously made about them, and as diet is the most important factor in the management of one of these classes, it is within the scope of this paper to direct attention to them. In one class the mothers are languid, feeble, and more or less emaciated, both during gestation and lactation. Abortions and premature deliveries are common. Their children at birth and during lactation are plump, well nourished, vigorous and good. The mother does not understand why her child can be so good and feel so well when she is so miserable. If a mother without organic disease feels miserable during pregnancy she will almost invariably give birth to a child fitting the above description.

In the other class the conditions are reversed. The mother feels well, is strong and looks vigorous during gestation and lactation, the child at birth is of the puny, half-starved variety and does not thrive as long as it is dependent on the mother for sustenance. It whines, cries and has the reputation of being a cross baby simply because it has a normal appetite and makes the only protest it can against an insufficient diet.

In the brute creation the analogue of these two classes is found in domestic cattle. The dairy cattle corresponding to the first mentioned class, and the stock cattle, or the variety raised for beef producers rather than milk, to the second class. I am sure this statement will be corroborated by the observations of those who have lived in the country. The weak mothers digest their food which is not used to nourish their own bodies but that of the child in utero and to supply it after birth with an abundance of milk. The strong mothers digest their food and in addition apply it to their own nutrition at the expense of that of the child.

Only theories can be given in explanation of these facts, and hence not satisfactory. For the weak mothers most benefit is obtained by giving prepared food. Murdock's has produced the best success in strengthening the mother during

the periods of gestation and lactation without the least detriment to the child. In cases of this class who have previously been pregnant and shown their usual tendency to miscarry or have premature labor, it is the only treatment I have found that may be used with any reasonable degree of certainty and comfort to the patient. For the strong mothers having weak children there is no treatment, dietetic, hygienic or medical, that will help the child before its birth. Deprive the mother of sufficient quantity and quality of food and she suffers; give her any kind of food and she appropriates it to her own tissues. After the child is born the right course to pursue, and there is but one right course, is to resort partially or wholly to artificial feeding. The stereotyped advice that the mother's milk is the best food is just as pernicious for this class of cases as that which prescribes milk in all cases of typhoid fever.

Special mention should be made of nausea, constipation and albuminuria because they are so liable to occur during pregnancy. Nausea, when strictly the nausea of pregnancy, cannot be either controlled or palliated by diet. When it occurs at certain periods of the day food should be avoided at that time. When it is continuous the food should be predigested and given to the patient while in a recumbent position. In some of these cases coffee without cream or sugar will be tolerated. In severe, or long continued nausea, the following is advised: Partially predigested milk or gruel, malted milk, somatose, or dry, nicely toasted bread. Food should be given every three hours. If the case be so severe that it will be ejected soon after ingestion, nutrient enemata should be given every four to six hours. Partially pancreatinized milk, beef and white of egg may be used with success. Avoid the use of fats and starches in the enema, and observe the same care to prevent the expulsion of the food and irritation of the rectum as in other conditions requiring rectal alimentation. But this reflex symptom must be controlled by other than dietetic measures.

Constipation, so common in women, is usually aggravated during pregnancy. I believe much harm, often serious, is done by permitting this condition to continue. It causes malaise and elevation of temperature, the latter most frequently during the post-partum period. For seven or eight months of

pregnancy it can best be met by observance of such dietetic regulations as are commonly advised for constipation. But during the last month or two of the term, when there is a mechanical factor in the producing cause, it is best to give less quantity of food having large residue and more having a smaller amount. When this condition exists a full quantity of fluids, seventy to eighty ounces, should be taken in twenty-four hours. A tumbler of water in which one-half teaspoonful table salt has been dissolved, taken in the morning at least half an hour before breakfast, will help cure the case of constipation. The water, without the salt taken at that time, is also effective. Corn-meal made into mush, corn cakes or corn bread, also parched corn, should be added to the other foods eaten to meet this trouble.

I agree with those physicians who believe that the urine of a pregnant woman should be occasionally examined for albumen, and when it has once been found in any case the amount of proteids given should be reduced and maintained at a minimum even though it disappear. There is a predisposition to its recurrence. If severe, the diet should be exclusively milk, to be continued for two weeks after labor; if not severe, a small proportion of meat may be taken, also fruit and vegetables. Alcoholic beverages, all of them, should be prohibited.

The unaccountable craving for some special article of food that is met in some pregnant women should be gratified to the extent of taking a reasonable amount. I do not wish to be understood as advising that a craving for albumenoids in those cases having nephritis, nor for carbohydrates in those having diabetes, nor in any other condition when the desire is manifestly due to some disease in which the article craved is clearly contra-indicated.

During labor, if it be of short duration and the woman strong, food should not be given. If the woman be in a weakened condition, or if the labor be more than seven hours' duration, liquid food should be taken. Coffee, beef broth and milk are the best. The first two are stimulating in their effect, without any reaction. This advice, if followed, conserves the strength, lessens the danger of post-partum hemorrhage, and enables the patient to better endure the necessary assistance

in difficult labors, and the immediate repair of lacerations. The ingestion of food during labor will relieve some cases of nausea.

The old theory that eating after labor will produce fever is erroneous. During the lying-in period the woman should receive food. She has much to do at this time. The discharge of lochia, repair of lacerations, beginning of uterine involution, change of colostrum to milk secretion in sufficient quantity and quality to meet the necessities of the child are some of the physical demands which require for their accomplishment a force that is best obtained from a sufficient supply of proper food.

Marked beneficial results have been obtained by giving dry toast and a small cup of coffee or tea half an hour after completion of labor, especially if the patient be exhausted, is the benefit realized by herself. For the first twenty-four hours after delivery the food should be largely liquid, broth, beef tea, milk toast, soft boiled eggs and plenty of pure water. Then if she be in a normal condition solid food sufficient to meet her desires should be allowed. If puerperal fever develops, the diet should be liquid, given according to rules for feeding in fevers.

During the nursing period all classes of food should be taken in the same proportion as in other healthful conditions. The quantity and quality of the milk is best maintained by keeping the system in a normal state, and not by the ingestion of any one article of diet or class of food. Of course, the food should be pure, taken regularly and thoroughly masticated. Alcoholic beverages should not be allowed, they do not increase the quantity of milk any more than does water. The latter will not only increase the quantity but also the solid constituents of the milk.

I repeat, in closing, that it should be borne in mind that pregnancy, parturition, and lactation are not diseased conditions, and the woman should not be made ill by a restricted or abnormal dietary. If she has any disease the diet suitable for it, when the above conditions do not exist, should be given.

ACUTE INANITION.

BY A. M. LINN, M.D., DES MOINES, IA.

Read before the American Institute of Homeopathy, June, 1898.

Inanition means starvation. Starvation is usually accepted as indicating death from want of food, while inanition applies to an inability to assimilate the food taken. The non-assimilation may be due either to the poor quality of food or to the inability of the system to appropriate the requisite nourishment to sustain itself. Of these two causes of inanition the former is much more frequent. In crowded tenements in the poorer sections of cities the eye of the physician often falls upon the bony, impoverished child starving for want of proper nourish-The innutritive quality of the mother's milk may be due either to her own ill health, mental or physical, or to overwork, or faulty self-nutrition. The result is inevitable; the infant becomes weak and scrawny from lack in quantity or deterioration in quality of its nourishment. Children born in such surroundings, where comforts are few and the bare necessities of life often wanting, are especially liable to inanition. They want sufficient vitality to begin the vegetative process or soon cease to struggle. Feeble nature makes but a weak, ineffectual effort at nourishment and unless supported the child soon dies of inanition.

SYMPTOMATOLOGY.

Acute inanition means quick starvation. It may supervene upon a pre-existing mal-nutrition or as the result of exhaustion from disease. It is much more frequent among infants and does not occur often after the first year of life. Few marked symtoms manifest themselves in the course of inanition. The emaciation may not be remarked until it has made much progress. The observant mother may have noted only that the child is ill. He may be petulant, or, more frequently, listless. There is either a fair appetite or an indifference to food. Sometimes the child will take no food, or, at most, but an ounce or two in the twenty-four hours; an amount totally inadequate to support the system. Vomiting does not often occur. Diarrhea is a more frequent symptom, and the un-

digested character of the evacuations may help to a diagnosis of poor assimilation. Less frequently constipation obtains. The child soon manifests an aged appearance, the skin wrinkles, the eyes become glazed and sunken, the thermometer reveals a sub-normal temperature, the heart's action is rapid and rather feeble. The whole picture presented by the symptoms indicates a threatened early collapse of the vital forces.

Many of the cases coming under your care result from want of assimilation of food. The abrupt or partial failure to take food is usually preceded by a period of gradual decline. It may come as a sequel to marasmus. Few cases will be found that are wantonly starved. The decline in weight and in strength continues for a time, when nature, somewhat exhausted, abandons the struggle; the child refuses the proffered food or takes so little that it is utterly inadequate to sustain life. Or, it may result in this as in ordinary cases of starvation. The first hours the pangs of hunger are very severe, but gradually diminish toward a time of comparative indifference. The exhausted nerves of the vegetative system issue no urgent call for nourishment. The system reposes in a condition of comparative quietude and indifference to food. Unless some unusual stimulant is applied the case progresses to an early fatal termination. One case of this type in my practice was saved by the use of predigested peptonoids. (Fairchild Bros. & Foster.)

Another form of inanition has been noted in a lying-in institute for unfortunates of which the writer has charge. In this normal appetite is present at any time; the system seems to crave no food. The child will neither nurse nor take an adequate amount of food in any form. These cases, conceived in sin, gestated in sorrow, and born in an atmosphere of grief, seem to want the ordinary appetite of a new-born child. They grow weaker and rapidly lose in weight and strength and shortly die. Others seem to thrive for a time; but if from some cause a change of food is made they begin to fail, and even a copious supply of the previous nourishment fails to check their decline. No available means seems capable of preventing the rapid progress of emaciation and they soon pass away.

PATHOLOGY.

No definite pathological changes have been noted as resulting from inanition. Indeed, it is more definitely described as a suspension of function than as a pathological lesion. Either as a result of poor quality of food or too scant a quantity, or both, the impoverished nerve centers controlling nutrition cease performing their allotted function. The suspended operation of the impoverished nerves means a cessation of the vegetative function. Life continues as long as the involuntary movements of respiration and circulation, spurred by the systemic call for oxygen, can compel them to act. When no longer able to respond to these appeals the spark of life goes out, leaving no pathological change of sufficient moment to attract attention. Of course there is great emaciation and loss of weight, but these are the results and not the cause of the disease. The intestinal villi undergo no considerable change. Beneath a high power lens the nerve cells of the brain will be found shrunken and shrivelled, plainly revealing their inability to generate the required nerve force to stimulate vital activity sufficient to maintain life. The child dies not because of structural changes, but because of suspended function.

DIAGNOSIS.

No pathognomonic symptom marks this disease. According to Holt, it is "distinguished from mal-nutrition by its greater severity and from marasmus by its more acute character." The following diagnostic features are present in most cases: The rapid emaciation, partial or complete, loss of appetite, quickened pulse, feeble heart's action, coldness of body, loose, wrinkled skin, subnormal temperature, anxious expression, sunken and glassy eyes, bowels loose or costive, etc. With these symptoms in one's mind, varying in gravity from light to severe, according as the case in its inception or approaching dissolution, one is not likely to make an error in diagnosis.

TREATMENT.

The treatment of inanition is not usually attended with a full measure of success. The powers of assimilation seem to weaken the general progress of the decline and demand most energetic measures to awaken them to renewed activity. When

insufficient food is the cause the means of relief is easily determined. A supply of nutritious food, gradually increa ed in quantity, is both the means of relief and essential to the cure of the disease. When the nourishment is faulty in quality the disease is more difficult of determination and of remedy. In the case of your little patient the time is short and "whatever is done it were well done if it were done quickly." No time can be spared for doubtful experiments. A few brief hours, or days at most, and the sands of life will run past that critical point where recovery is possible. Every effort should be made to secure a wet nurse for the patient. Failing this. diluted milk should be used, well peptonized, and given at rather frequent intervals. At one instance in the writer's practice success was obtained from the use of malted milk, and in another from peptonized milk. Soups and broths are generally worse than useless. It is a well-known fact that the body is more quickly robbed of its vitality in a cold atmosphere. Careful attention, therefore, should be given to maintaining the temperature of the body by the use of warm applications; also sponging the body frequently and applying moist compresses may be helpful. Where vomiting is persistent, or there is a refusal to take sufficient liquids, life may be prolonged by the use of salt water enema. records one case in which he succeeded in saving life by means of gavage. For this purpose malted or predigested milk should be used. Numerous expedients may be resorted to in order to accomplish the desired purpose.

REMEDIES.

While the adjuvant treatment is important, the remedial treatment must not be neglected. No one can name the critical point of decline beyond which remedies cannot awaken a reaction. It is a proverb: "Where there is life there is hope;" and while the child breathes we should hold with tenacious grip to the spark of life. We may be as successful as we hope and more so than we expect.

The following named remedies may be consulted in the treatment of acute anemia: Sulphur, arsenicum, lachesis, calcarea-carb., china, nux-vomica, phosphorus, iodine, rhustox and thuya.

CERTAIN ETHICAL PHASES OF GYNECOLOGICAL PRACTICE.

SHELDON LEAVITT, M.D., CHICAGO.

Read before the American Institute of Homeopathy, June, 1898.

In every department of practice one early encounters responsibilities of a trying nature and is required to determine rules of conduct which involve ethical questions. It is for this very reason that medical and surgical practice should not be taken up by those in whom cupidity is the ruling passion, whose moral principles are not well settled and whose sensibilities are not morally keen.

In the popular mind the surgeon is a man of intrepidity and courage, and for these qualities to be admired; but a man also lacking in sympathy and that gentleness of spirit which should characterize one whose duty it is to inflict the severest physical suffering with a view to the betterment of the sufferer. It is true that the practice of surgery is in some sense a hardening process. The surgeon, as a natural result of familiarity with scenes of suffering and death, ceases to be profoundly moved by the emotions which often stir the ordinary heart to its very depths; but experience does not necessarily make of him a monster of cruelty, or a human butcher, as he is sometimes hysterically called, though we regret to say it sometimes does. That a surgeon ever becomes cruel in outward appearance, or even at heart, should be a cause of deep regret on the part of those whose sensibilities retain a modicum of pristine sensibility, and whose motives, despite the seductive influences surrounding him, remain of the purer and better kind.

The physician and surgeon, confronted as he is at the very cutset of his career, before he has given ethical questions due consideration, is apt to arrive at unwise conclusions, especially if deficient in moral virility. Your chairman is not disposed to set up any unattainable moral standards; but to consider before you certain points of conduct, with respect to some of which he admits there is ample room for more than one honest opinion. There are among us many who are inclined pharisaically to observe the letter, rather than the spirit, of ethical obligation,

ignoring the truth that moral principles rest not upon arbitrary requirements and mere conventionalities, but upon considerations of human interest and the ultimate good of mankind. Conscience, when unwarped by prejudice and blunted by disregard, prompts to one action and dissuades from another solely because the indicated line of conduct leads with unswerving certainty to the largest good for all concerned. According as we follow such dictation is individual and general evolution enabled to work out its beneficent results.

But now to the particulars. A moral responsibility which rests with much weight upon the conscientious operator, is that concerning his personal fitness to do well the surgical work required. The same sense of responsibility is felt by the conscientious physician with respect to his ability to serve well, by his medicines, the interests of his patient; but in medicine the real responsibility involved is not so great, owing to the fact that the possibilities of serious harm are not so pronounced as in surgery. The question: Am I well equipped, both in point of knowledge and mechanical skill, faithfully to serve the best interest of the confiding patient before me? is one which the operator ought seriously to propound to himself, and be able affirmatively to answer, before he puts a knife to the case. In order to be forearmed he should consider. with wise forethought, possible complications, and map out with scrupulous precision the available resources with which to meet them. In the opinion of your chairman there is a great deficiency of regard accorded these important considerations even by men of honest intentions. Not long ago your chairman was called some distance out of the city to do a uterine curetting for a practitioner of our school of medicine, and. in conversation concerning surgical work in general, this man of medicine who had felt himself incompetent to manage a case so simple in character as that which had just received our attention, expressed perfect confidence in his ability to do deft abdominal surgery. There is no intention to inveigh against the moral right of any one, however inexperienced, to undertake work for which he is theoretically qualified, since every surgeon must gradually wear away his novitiate characteristics. One is enabled to develop true skill only through experience, and these strictures are directed against those only who hold human health and life as commodities to be turned over to the tender mercies of a successful bidder, without regard to his qualifications as a trustworthy conservator; or who feel that to shrink from any undertaking, no matter how dangerous or difficult, is an indication of weakness. As a result of practice, it is true we acquire manipulative skill, and the confidence that affords so material aid is the actual doing of operative work; but we have no right to the necessary experience unless we have made ourselves familiar with each step of the procedure through clinical observation and faithful study. Anything short of this makes us mere jugglers.

Then there is the reckless surgeon. He may be well informed in regard to methods and general technique, and possess wonderful manipulative skill, but he is a reckless, impatient soul, hurried and goaded by undisciplined and refractory impulses. He jumps to conslusions, makes off-hand diagnoses; prides himself on short operations, and is little disturbed by unfavorable results. Comet-like he blazes in the heavens, and comet-like, fades before he reaches life's meridian. He fills, it maybe, a most important place in surgical evolution, and yet is the object of many a summons from the bar of moral justice.

For the brilliant achievements of such a one we feel a justifiable admiration, because the force of genius always commands it; but what shall we say of a surgeon of the oldschool who laughs at new methods, depreciates the value of strict antiseptic precautions, and is little moved from his old and well-beaten ways by the achievements of up-to-date surgery, however grand? It is true that he is sometimes constrained so far to countenance certain innovations as to commend them publicly; but his precepts and practice are widely divergent. When he goes to his work, after hastily preparing his hands, you see blue in the subungal spaces, and he avails himself of the most convenient aid, in the heat of an emergency, without questioning the assistant's preparedness. His percentage of loss is heavy, at which he is distressed, yet by it he is not reformed. What about this man's moral responsibilities?

But gynecology is not all surgery, and there are ethical lines reticulating the medical, as well as the surgical, phases of practice among women, that we shall do well to study somewhat in detail.

The gynecologist is subject to peculiar temptations which appeal to his cupidity, and among them we may reckon the opportunity to reap a harvest from women whose lively fancy and vivid imagination have made them mental invalids. Many of the women's ailments, as we all know, have their tap root in the mind, and such subjects accordingly become an easy prey to the unscrupulous doctor who has a dominant regard for filthy lucre. Women are apt to be controlled by their intuitions while their prejudices and prepossessions are not easily overcome, so that great tact and consummate discretion are indispensable to the attainment of the best results of treatment. They will not often tolerate raillery, or even pleasantry, directed at their supposed ailments, especially by a strange physician, and the part of wisdom is to handle their delusions in a gentle but firm manner, conceding to them by implication, some claims, of the genuineness of which we are not fully convinced, and giving to each symptom its due weight. It follows that a truly honest physician or surgeon may find it wise to resort to drugs, or even operative measures. to set in motion curative mental impulses and impressions in those who have become possessed by the idea that their only relief is to be found in operative measures, that nothing short of an operation is likely to effect a cure; while others have such an antipathy to surgery, and so great a fear of it, that its mere mention is sufficient to precipitate them into a state of direct mental and physical chaos. But to make traffic of mental weaknesses and morbid fears, instead of putting forth honest endeavors to correct them, is unworthy one who poses as a benefactor.

Should unmarried women be subject to thorough pelvic exploration? This question is often asked, and to it various answers are given. Some would have us make no examination except as a dernier ressort; but they are mainly those who undertake the management of all sorts of pelvic trouble without proper investigation, laying no emphasis upon the sur-

passing advantage derivable from physical exploration, and possessing no adequate knowledge of pelvic pathology.

It is alleged that besides the reduction of a girl's modesty resulting from such an investigation, currents of thought are directed to the generative sphere which may prove prejudicial to the health and morals of the subject. But have we not reason to believe that possible lesions, excluded by the results of an examination, or recognized and cured, had they been left to luxuriate in a sensitive subject would likely have produced pernicious results far outweighing those apt to be engendered by a well-conducted examination? The truth is there would be fewer physical wrecks among our girls if careful examinations were more common; for there are many remedial ailments, which, when neglected, work disaster to physical health and vigor.

And, again, when it is found that there are conditions which make vaginal exploration and intra-vaginal medication desirable, should we not set aside, if necessary, a prudish anxiety to preserve "the proofs of virginity" in order that the immediate diagnostic demands may be fully met? A young woman whose character is above reproach, and whose mien and bearing are those of a virtuous maiden, never requires physical evidence to convince a husband who is worth the having that her integrity is above question; while, on the contrary, a woman of wanton manners would not be able to establish her essential virtue by the possession of an intact hymen of the most elaborate form and dimensions.

The ideal physician has not yet been actualized in life. The best of us have our weaknesses. We are all bound more or less closely by conventionalities, and feel circumscribed by current habits of thinking and living. It cannot well be otherwise; but, as guardian of the physical and mental health of the community, we should resist the impulse toward servile conformity, and settle questions of morals, as well as those of contingent occurrences, for ourselves. There are many evils in every community, injurious to mental, moral and physical health, which merit rebuke. One of them is the marriage of young men and women whose children are apt to take on the physical weaknesses, and follow the vital tendencies, of their

polluted or degenerate parents. There are men all about us bearing in their organisms taints which are more to be feared than death; and yet we interpose no word of serious objection when we see them about to enter into conjugal relations with lovely and confiding girls, the fountains of whose purity, or the health of whose offspring will be exposed to the foulest contamination.

There is no denying that it is far easier to preach than to practice, for the truth is demonstrated in the lives of all, those of the medical fraternity forming no exception. Doctors ought to be wiser in matters pertaining to heredity than are the laity, but it is plain that they are not; or, to take a more charitable view of their attainments, they give most unwise heed to knowledge which they possess. But let us throw over them the cloak of charity, for love is a blind goddess, and the mesalliances among our brethren show that she is a blind leader of the blind. Let us pray that they may not all fall into the ditch.

The prevention of pregnancy is a question which has agitated physicians and social scientists to a phenomenal degree. It is a subject in which many feel a conscientious interest, and concerning which they recognize a profound responsibility. Laws have been framed which make it a misdemeanor to offer advice looking to the prevention of conception, or to furnish the means by which such a purpose is accomplished. Such laws are undoubtedly wise in their intention, and yet all of us are well aware that cases are not infrequent, wherein, as lovers of humanity, and as conscientious men and women, we feel a sense of obligation to aid in the prevention of conception by the best advice of which we are capable. It is all well enough to say that nature ought to be allowed to take its course, and that a kind providence will doubtless overrule apparent evil and out of it all evolve a high order of results. But with strains of insanity and other disorders in the subject; with dipsomania and continual intoxication in the husband, or tuberculosis and syphilis in the mother, united with a strength of impulse which makes neither party able to control the sexual relations, have we not a moral, if not a legal, right to extend the aid of our advice to prevent

procreation? These people should practice self-restraint, and perhaps they do; but total abstinence is quite another thing, and is hardly to be expected. Besides, physical and mental depression is liable to follow protracted absque marito in the conjugal state. The study of social science cannot wisely be separated from that of physiology and pathology, and any attempt to do so is certain to result in an incompleteness which cannot fail to render rules of conduct and proposed plans for the betterment of social conditions relatively partial and unpractical.

Your chairman presents no plea for leniency of judgment upon these Malthusian ideas, for he is strengthened by the conviction that they represent the consensus of professional opinion.

This leads us to a consideration of the larger question of abortion, in which gynecologists, as well as obstetricians, should feel a deep interest. We cannot too strongly condemn the practice in general, whether undertaken by women upon themselves, or by unscrupulous physicians whose cupidity has acquired a mastery. It is one of the crying evils of the fin-desiecle, and is bringing upon those who are subjects of it numerous and serious ailments, as we gynecologists stand ready to testify. But what is astonishing is the general apathy concerning it. Notwithstanding the heinous nature of the offense in the eyes of God and men, we hear few voices publicly raised in condemnation. Women share each others' confidences and become mutual instructors, treating the subject so lightly as to break down moral sentiment and overcome conscientious scruples to a lamentable degree. The clergy, while not hesitating to raise its voice against other evils, appears to regard this as a forbidden topic; and even physicians are not always disposed to condemn the act in the terms which its evil nature deserves.

But there are features of this question of abortion which many are disposed to overlook, and which the law fails to recognize, well worth serious consideration. It is conceded that for the protection of maternal life the physician is justified in inducing premature expulsion of the product of conception; but are there not other considerations which should be regarded as sufficient justification of the act? Your chairman will not attempt to recite them, but as an example he will point to a pregnancy in which the parents are criminals or drunkards.

It should be added that there is no intention to suggest larger liberty for the individual physician in the practice of abortion, but rather the wisdom of a provision, in the interest of society, for wider discretion to be accorded an established medical council, or a definite number of physicians assembled to consider the case. Such a suggestion some of our wise and prudent may regard as a mere fantastic conceit; but when we see the sins of parents so often visited upon their innocent progeny, we cannot but feel that further effort should be made to limit and circumscribe such deplorable results of uncontrollable indulgence.

It may be that a more practical and less objectionable method of controlling such conditions is to be found in the establishment of a marriage license board, made up of physicians who shall refuse permission to marry in all instances of mental, moral and physical disqualification.

Another pertinent suggestion, and one which your chairman has long sought an opportunity publicly to make, is that of castration of all criminals, both male and female, who are found guilty of grave offenses. There is undoubted heredity in criminal impulses, and society has a right to demand protection from its baneful influences.

While the foregoing are matters in which medical men and women in general should manifest a deep interest, they are of special concern to gynecologists, and for this reason they have been here introduced. But we come now to consider a few specific questions of an ethical import concerning the practice of gynetic surgery.

First of all let us bring up the question of capital operations for the possible relief of nervous symptoms. It has been quite uniformly conceded that there are few conditions not menacing to life which justify invasion of the peritoneal cavity. At the same time we cannot but recognize a disposition of surgeons to extend the benefits of their superb science and art to the re-

lief of conditions not necessarily inimical to life, but decidedly so to health and comfort, even though it involve entering the sacred precincts of the peritoneum. It cannot be denied that a protracted and helpless state of invalidism, especially when accompanied by pain, renders life hardly worth living, and forces one to the adoption of possible means for relief even at the expense of some risk to its continuance. This avenue of escape for the valetudinarian has been much widened of late, and has been more inviting by reason of the reduced mortality resulting from asepsis and improved technique. Under proper safeguards the impulse is entitled to moderate encouragement, though it must be confessed that there is danger of the movement carrying us to an unwise extreme. Your chairman cheerfully admits that his own convictions have undergone considerable change during the past two or three years, in the face of which he still accounts himself a conservative surgeon.

Another question over which a great deal of sentiment has been shown is that of removal of the ovaries from unmarried women. There is no doubt that about the generative sphere gather the strongest forces which make for connubial peace and happiness. All true sentiment between the sexes springs from it, and it is manifestly unfair to womankind unnecessarily to mutilate or ablate the sexual organs. Removal of the ovaries has probably been practiced to an unnecessary degree; and yet, with all the recklessness that has been charged to it, we have reason to believe that the operation has a surplusage of good to its credit. Some lives have been lost, and in a few suffering has been increased; yet on the whole it is probable that these evils have been more than counterbalanced by the renewed vigor and restored peace of mind brought to the many. Let us remember that all surgical measures find their justification in the preponderance of good which they bring to suffering humanity, and the aid they give to the forces which are steadily elevating and ennobling the race.

There are many who take a narrow physical view of such questions, exalting mere sensual gratification above the essentials of true living. We should not reckon it as woman's chief function to be pleased and pleasing plaything of selfish husband, or to co-operate to the maximum in populating a sphere

already teeming with human life. But then we have no good reason to suppose that the relief of a woman from the agonizing disturbances growing ont of imperfectly developed genitalia, even at the expense of their aglation, to so change her womanly nature, or so injure her instincts, as to disqualify her for discharging the duties, bearing the responsibilities and performing the delightful ministries of married life. And even should it cause her to enter into sexual relations with diminished zest, we are not hastily to infer that the sum total of human happiness would be thereby in the least reduced.

It is evident, notwithstanding the recently developed disposition to extirpate the uterus along with diseased appendages. that the surgical mind inclines more and more to what may be reasonably regarded as conservative surgery. To such a degree does this disposition characterize some operators, that, rather than deprive a woman, even though married and already the mother of two or three children, of the organs essential to reproduction, as, for example, the ovaries in their entirety. they prefer to compromise to a serious degree the patient's chance of complete restoration to health by a resection of the ovaries. rather than destroy the possibility of further childbearing by complete excision. The surgeon does not have every case committed fully to his discretion, and hence may be limited to a one-sided operation. But when left to conduct a case according to his own judgment, he should remember that moral considerations may dictate most radical measures. In making up a verdict under these conditions the patient's constitution, both mental and physical, is entitled to close scrutiny and much weight. While, in a given instance, doubt of the advisability of complete removal of both ovaries may be reasonably entertained, provided the patient possesses a constitution disclosing none of the evidences of morbidity so often witnessed, in another case, presenting the same operative requirements. but with the ear-marks of serious dyscrasize or mental aberration, there is left but little room for honest doubt. Women long to become mothers, but we know that many of them are mentally, morally or physically unfitted for maternity, and in the way of such ought to be thrown every rational hindrance of fruitbearing by those who are in some sense the constituted guardians of society.

Your chairman doubts not that he will be regarded by some as lacking in regard for ordinary conventionalities; but he is not disposed to forestall such opinion by either qualification or denial. It is but fair, however, that he be permitted to repeat what has already been implied, that the intent herein is chiefly to interrogate thoughtful minds, and present ethical problems deemed by him highly important, but much neglected, with a view to betterment of present conditions. The beaten path is not always the best one, and popular opinion is not always the wisest. "Whoso would be a man," says Emerson, "must be a noncomformist." The medical man, the medical woman, are projected into the very midst of moral questions requiring delicate treatment, deliberate consideration and wise decision; and they are to be congratulated who meet such responsibilities in an earnest and honest spirit, and bear them to wise and happy issues.



ANEMIA AND MARASMUS.

BY B. F. BAILEY, M.D., LINCOLN, NEB.

Read before the American Institute of Homeopathy, June, 1898.

We have been thankful that the term scrofula, that cloak which for so many years "covered a multitude of sins," has become practically obsolete. The attempt, however, to define more intelligently and in better keeping with scientific knowledge has not been and is not without its difficulties. That the many manifestations of the formerly so-called scrofulous diathesis are due to malnutrition can hardly be controverted. That the first evidences of this malnutrition are found in the blood is probable, but a hematic differentiation, so that we may be able to tell what change in the blood leads to anemia, what to rachitis, what to marasmus, what to this pathological form, and what to that, is as yet impossible. The term anemia, hitherto signifying a deprivation or impoverishment of the blood, may now be considered to also refer to changed conditions of the blood, and may be assumed in some of its forms to be the probable initial field of the numerous diseases of malnutrition.

It is true there are certain diseases which we can diagnose from the study of the blood, which are the diseases of so-called primary anemia. There are others which in turn impoverish the blood and are called the cause of secondary anemia. Thus if I be allowed, I will assume that primary anemia results in certain diseases, whereas secondary anemia is the result of certain diseases. For example, the diseases of primary anemia are, first, chlorosis, with its normal or nearly normal number of erythrocytes, though they may be abnormal in shape (poikilocytes), or unusually large (macrocytes), or at times, perchance preternaturally small (microcytes), but always deficient in the coloring matter of the blood, hemoglobin. An increased number of leucocytes (leucocytosis) is not common. In brief, not a condition of decreased red blood corpuscles (erythrocytes) or increased white corpuscles (leucocytes), but of deficient hemoglobin.

Second. We have as a primary anemia, pernicious anemia, in which there is a very great diminution of erythrocytes, a

moderate diminution of leucocytes and an increase of hemoglobin. The large red blood corpuscles with fragmented nuclei megalablasts are very common in this disease.

Third. Anemia infantum, or pseudo-leukemia—a rare form with a lessened number of erythrocytes (oligocythemia), lessened hemoglobin (oligochromenia), an increased number of white corpuscles, or leucocytes (eucocytosis)—considerable enlargement of the spleen, little change in size of liver, with an enlargement of the lymphatic glands, which is general and not excessive.

Fourth. Leukemia. This disease presents two forms: the splenic and myelogonous, or spleno-myelogonous, and the lymphatic. In both forms there is a marked increase in the leucocytes and diminution in the erythrocytes. It is not alone that the leucocytes are increased, but the myelocytes or large mononuclear neutrophiles are in abundance in the spleno-myelogonous type; while the small mononuclear leucocytes, or lymphrocytes, are absent. In the lymphatic type the leucocytes are not so largely increased, but the lymphocytes are increased proportionately, making, instead of as normally, 25 to 50 per cent of the entire leucocyti count sometimes as high as 90 per cent of the total count, and the myelocytes found normally in the marrow of the long bones and abnormally in large per cent in the spleno-myenogonous types are rarely if ever found in the lymphatic type.

The secondary anemia, that is, the anemiæ that are in a general way considered to be the result of previous conditions, and not the cause of them, are usually due to some of the following conditions, although it is probably true that all diseased conditions result in a greater or less degree in anemia. The special causes of anemia are hemorrhages, acute infectious diseases, syphilis, intestinal affections, tuberculosis, etc. Most authorities also mention as causes of anemia thachites neoplasius, diseases of the skin and bones. I must, however, take exception to this view, and until proven in error shall believe that existing evidence indicates the changes of blood found in these diseases to partake more of cause than effect. To generalize, the so-called secondary anemia should be discussed as effects or sequelæ of the diseases which cause them.

Of the primary anemia, chlorosis proper is rare in children. Some doubt if it ever occurs, as, for instance, Weiss; while others, like Henrod, are equally insistent that it does occur. It is probable that it does occur in a modified form. Progressive pernicious anemia is usually fatal, except in the one type of the disease which has been caused by intestinal parasites and hence was a secondary, not primary disease, recovery ensuing after the expulsion of these parasites, namely, the anchylostoma duodenalis and the cothriocephalus latur. All attempts to prove the disease the result of micrococci have thus far failed.

Anemia infantum, pseudo-leukemia, is very fatal in its progress either from the course of the disease itself or from intercurrent diseases. Leukemia, too, is held to be a most fatal disease, the spleno-myelogonous type perchance offers the most real hope of a prolonged life, while the lymphatic may offer the most apparent hope. I believe, however, up to this time, the lymphatic type had been universally fatal.

Marasmus is now written of under the name of infantile atrophy, under the technical supposition that marasmus being a symptomatic term it should not be used as designatory of a disease; but, again, I fail under the best writers and authorities to find infantile atrophy anything more in its meaning or its elucidation of the subject than the older term marasmus. Pardon me if I here register a most emphatic plea against the continual increase of terms and terminologies which, so far as utility is concerned, add nothing to our lore except a chance for the display of a seeming knowledge and a wearisome labyrinth for the student.

In this disease we have extreme atrophy, wasting of muscular tissue, without evident disease. The symptoms are those of gradual starvation. Actual lessening of weight of body, of muscular tissue, with sometimes slight enlargement of some of the lymphatic glands usually present, increased excretions from the bowels, though the skin is commonly dry, stools quite apt to be loose, vomiting may occur, though it is not common, patient is usually fretful and moans as if from indescribable suffering or weakness. Temperature may be normal or slightly increased or decreased. Rotch says: "It is probably due to a

vice of absorption." One of the most difficult things, and yet perhaps one of the greatest and most useful, to learn to say, is, "I don't know." Evidently Rotch had not learned this, for he expressed little else in his "vice of absorption." It is commonly admitted that the cause of marasmus is unknown. To be sure, it often seems to be due to some grave intestinal affection, but we find ourselves unable to distinguish in any demonstrable particular the difference between two similar intestinal conditions, the one benign in its results, while the other is marasmatic in its trend.

The diagnosis is not always easy as between tuberculosis and so-called atrophy, several writers stating that the symptoms presented are exactly the same, even to a similar elevation of temperature, post-mortem examination or recovery only solving the problem.

It is a very intractable disease, but not by any means hope-After all, what have we? A few demonstrable facts of histology, and our clinical memories and theories deduced therefrom. No one has been able to do better than this. Hence we too may be pardoned if we dare in the light of our knowledge and experience to theorize in a simple way. Throughout all nature the inorganic salts seem to have a wonderful office. In one place their office seems to be chemical in another catalytic. Not always as easy to demonstrate the positive office of their presence as the dissolution resulting from their absence. Maragliano advanced the theory that serum deficient in these organic salts was destructive to the erythrocytes or red blood corpuscles. If perchance this be true, we have then to consider whether a serum barren of inorganic salts is destructive from a toxicity or whether it is only negatively destructive from a lack of cellular nutritive. We know that in the serum there is a predominance of sodium salts over potassium salts; also an advance of chlorides, but a scanty supply of phosphates. Now we know that these salts are the very ones that favor rapid absorption, and osmosis, and we may, consequently, believe they in this way favor active nutrition. Further, we know that when uric acid is most in evidence in the system it is often scant in the urine; and, therefore, it is but a reasonable proposition that in a normal condition of blood-serum the phosphates and proteids are rapidly taken up by the corpuscles; whereas with a minimum amount of the inorganic salts in the serum there is a tardy disappearance of the salts of the ailments and, hence, imperfect nutrition. To carry our argument still further the corpuscles of blood both contain as vital element of their composition a proteid matter of which nuclein is a prime factor, and nuclein is rich in phosphates. Without these phosphates the nutrition of the corpuscles cannot be efficient, and with imperfect corpuscles the general nutrition of the body must suffer from autointoxication, in that the activity of the lymphatic system is probably impaired by a lack of vitality of the white corpuscles, while the imperfect oxygenation resultant from weakened erythrocytes must prevent prompt disassimilation and rapid carrying away of debris. For instance, in the splenomyelogonous form of leukemia, we find a surplus of old cells, the myelocytus, while new ones are not forming; the balance is lost and we have an anemia cachectic in character, with the evident auto-intoxication which is found in all anemiæ. Again. in the lymphatic type of anemia we find the lymphocytes which we may with reason assume to be the younger corpuscles in abundance, while there is a drouth of the older form, and, hence, there is in the lymphatic system a rapid formation of embryonic tissue, not a neoplasm proper, but an embryonic hypertrophy. That I may not trespass or be tiresome, let us see in a few words what we may properly deduct from these assumed facts.

First. Inasmuch as we cannot find early pathological conditions in other parts, and inasmuch as in all cases of anemia, marasmus and malnutrition are to a greater or less extent evident, we may judicially deduce the theory that the seat of primary anemiæ and marasmus is in the primary laboratory of the body; the blood.

Second. Inasmuch as the processes of the body are largely chemical in character, the forces thereof being vital in origin instead of the manipulation of the chemist, it is but fair to presume that certain conditions and elements must be exact to bring certain results, otherwise we will have as in the more delicate work of the laboratory or of the electrical, an im-

perfect conclusion, and that this conclusion is certain to be imperfect unless the primal steps are exact.

Third. Admitting this to be true, yet it is often difficult to trace the error in the laboratory, and impossible in the human domain, but the difficulties only render it more imperative that we should adopt a reasonable hypothesis, and work it out to either a negative or positive conclusion, until we find by results that our hypothesis is a fact and that our unknown quantities can be named.

Fourth. Taking these assumptions together with experience for our authority we find in children that may present themselves for our care as anemics and marasmatics a small heart with vessels as large or larger in proportion than we find in health or in adults, a condition which in the adults in low tension of circulation, and a tendency to fatty degeneration and poor muscular and hematic nutrition, and a weakened power of assimilation of inorganic salts. In the adult this may be endured for a long time, because the firmer tissues of the body, as the bones, et cetera, are formed and are at least for a certain time, permanent. On the other hand in this type of child we find more formative cells but less fibrin and hemoglobin; thus a striving of nature under imperfect conditions to provide for the growth and nutrition of the child, resulting in rapid formations, but more rapid degenerations because of the formations of embryonic and other than mature types.

Accepting these theories, which at least to me seem reasonable, we are ready to consider how we may by treatment correct these errors in nutrition and growth. First strengthen the heart and blood vessels by careful massage and by the administration of the 2x of strychnia in doses of one-fourth drop morning and night. Second, correct the tardy assimilation by the administration of natrum phos., if there is evident acidity of the system; or of natrum mur. should the symptoms by their indications evidence a lack of chlorides; following these with calcarea phos., ferrum phos., kali phos., magnesia phos., or some of these nutritive remedies; remembering that Schuesslerism is but Homeopathy which Schuessler did not understand. That by administering these remedies we do not seek to supply the need, but to so correct the powers of assimi-

lation that when we supply the system with food rich in the needed salts, they may be properly appropriated and not hurried into the sluice-ways of nature.

Our foods in marasmus must be contrary to the usual formulæ; at first rather high in sugar, low in fat, and rather under than over in proteids. As strength increases fat may be increased as the system strengthens enough to dare its appropriation without injury. Many a case may rapidly benefit by adding to the milk a small quantity of calcarea phos. and magnesia phos., which renders the caseinogen of the milk more easily precipitated and digested. This being a nucleoproteid aids in the restoration of the proper ratio of nuclein of the corpuscles. In extreme cases it is wise to use in small doses as food, protonuclein; or where calcarea phos. fails though seemingly indicated, we may use the glycero-phosphate of lime, which is the nearest salt akin to that of the lichthium of the corpuscles and nervous system that we have, and which in my hands has given wonderful results in certain cases.

Do not forget in cases refusing after all aids to properly oxygenate the blood, to give teaspoonful doses of glycozone, which I can assure you has saved lives for me.

But though so large a subject, so small is space and time, that only a few thoughts have been jotted down. He who thinks and works must read between the lines.



ECTOPIC GESTATION.

C. B. KINYON, M.D., ANN ARBOR, MICH.

Read before the American Institute of Homeopathy, June, 1898.

We have a right to assume that doctors are human, possessing the same love of fame that other mortals possess. This being true, we need not be at all surprised that many medical writers, teachers, practitioners and operators are inclined to emphasize the newer ideas. Putting forth their best endeavors, in contriving or discovering something new. Neglecting or overlooking the older, and oft-time well established, principles and methods.

This same element in human nature is responsible to a great extent for the present extreme tendency toward specialism in medicine.

Few are possessed with sufficient perseverance and pluck to fully prepare themselves so as to properly cover the whole field of medicine.

In this rushing, competing age, all feel that they must push for success at once. Hence they hasten to perfect themselves as best they may in one special line, failing to fully grasp the interdependence existing between diseases of the different parts of the system. The above general considerations being true, I have no apology to offer for bringing to your notice at this time the subject of ectopic gestation. For of all the obstetric complications which we may be called upon to meet, none presents a greater diversity of phenomena. No condition presents greater complications. None require more accurate diagnostic skill. None will test more fully all the powers of the attending physician. And what is more, there is no condition which proves more surely and more rapidly fatal, unless the right thing is done at the right time, and that time is necessarily short and comes very often without a moment's warning.

The Scriptures tell us that each generation grows weaker but wiser.

The fact that the present generation is weaker may perhaps

justify us in concluding that ectopic gestation occurs more frequently than formerly. For ectopic gestation does not take place in a strong and healthy woman. Or it may be that we doctors of this generation, being wiser, have reached a greater perfection in diagnosis, and thus it is more frequently discovered. Be this as it may, the fact remains that in the past thousands of women have died from ruptured ectopic gestation sats whose death was attributed to peritonitis, to pelvic hematocele, or, perhaps, to heart failure. What a consolation it must be for some doctors to remember that their patients have hearts, and that hearts sometimes fail. Just a word at this point regarding hematocele.

During very recent years, a great change has taken place in the minds of our best thinkers, writers and operators regarding their opinion of the cause of pelvic hematocele. At least seventy-five per cent, and some put it as high as ninety per cent, of the cases of pelvic hematocele are due to ruptured gestation sacs.

This will not surprise us when we remember how early the blood vessels of the uterus increase in size. One of the most important of the fœtal appendages, the chorion, begins to form on the twelth day after impregnation of the ovum, and its villi form very soon thereafter. The capillary loops in these villi are quite large and bleed freely when ruptured. One other important fact is worthy of elaboration. The impregnated ovisac may rupture and severe hemorrhage follow before the naked eye can distinguish the sac. But the cells of these villi are readily distinguished by the microscope very early. Several cases have been operated upon and reported during the last year, or reported at time of autopsy, as the case might be, wherein the only positive evidence of ectopic gestation was found in the cells of these villi.

All other traces were absorbed or the rupture was too early for other tissues to be developed. We thus see that the microscope is not only of great value, but it is often our sole means of making a correct diagnosis in some cases of ectopic gestation. As it is only with the microscope that one can distinguish between the decidua of dysmemorrhea, the uterine decidua of ectopic gestation, without the chorionic villi, or the

uterine decidua of abortion with these villi present. With all the symptoms of pregnancy present, but no chorionic villi in the discharges from the uterus, we are justified in concluding that ectopic gestation is present. Of course our examination of the discharges must be thorough and exhaustive, but its conclusions are almost absolutely safe.

I have now given you the cue as to why it is possible for the recent observers to speak with such positiveness regarding the fact that ectopic gestation is the chief cause of hematocele.

The first clear description of hematocele was given by Nelation in 1850, but he did not give its true cause.

The first successful operation for ruptured tubal gestation was performed by Lawson Tait in 1883.

A third of a century during which the true cause of hematocele was not suspected.

Before then ectopic gestation was looked upon as a freak of nature and was very rarely diagnosed. We now know it to be very frequent indeed. It is generally conceded that all cases are primarily tubal. Abdominal pregnancy does not occur primarily, and it is very doubtful if the ovarian form does. The fecundated ovum may be located altogether in the tube, or it may be between the tube and ovary—tubo-ovarian—or it may be tubo-uterine. The tubal is by far the most common form. The tubo-ovarian is still in doubt, but some excellent authors claim that the ovum may be impregnated while resting in the fimbriated extremity of the tube.

Exudates and adhesions form around it and bind it to the ovary. But as this form cannot be distinguished during life it is not worth while to spend more time upon its discussion.

The tubo-uterine occurs in that portion of the tube embraced by the uterine wall. As this occurs so very seldom, I will dismiss it with few words. It does not rupture before the sixteenth to twentieth week, as the uterine walls are capable of distention and will resist rupture longer than the thin non-muscular walls of the tube. The products of conception may find their way into the uterine cavity, but, as a rule, rupture occurs into the abdominal cavity, and is rapidly fatal as the hemorrhage at that stage and in that location is simply fearful and hard to control, as you cannot reach the arteries in time

to save the mother. It can generally be diagnosed from the tubal form by its being so closly bound to the uterus, or it may bulge into the uterine cavity. In this latter case the treatment is readily outlined.

Simply dilate the cervix and deliver.

CAUSES.

As the cause has little to do with the treatment, I will say but little about it. Changes occur in the calibre of the tube from inflammation. This inflammation may produce desquamation of the epithelium, or stenosis from adhesions. Or, from cicatricial bands around the tube, forming pouches for the lodgment of the ovum. Some authors claim that th ovum is usually impregnated in the tube. If this is true, it will not be so difficult to understand why this form of pregnancy is so frequent. For after impregnation the ovum rapidly increases in size and it is very liable to be obstructed at the isthmus of the tube.

Changes also quickly take place in the tube. The walls at first become thicker, because of increased blood supply. This continues for about two weeks. Then the walls begin to grow thin from stretching due to growth of ovum. The walls also grow weaker from the ingrowth of the chorionic villi. The fimbriated extremity gradually narrows and is closed completely at the eighth week. Tubal abortion is not possible after that time, and the rupture can occur only in the tubal wall. The rupture may be hastened by external causes, such as lifting, straining, a sudden unexpected misstep or coitus. From internal causes, such as hemorrhage from or separation of the tubo-chorionic vessels. The rupture may take place through the portion covered by peritoneum into the abdominal cavity, or it may rupture through the part not covered by peritoneum, into the folds of the broad ligament. Classified as intra and extra-peritoneal rupture. Intra-peritoneal rupture is often immediately fatal. If the rupture is small, and is not near any important blood vessels, or the opening is filled up by the chorion, the hemorrhage is not fatal. The blood collects gradually in the cul-de-sac and slowly clots, and peritoneal adhesions soon toof it in. The adhesions may become organized into a new sac. This new sac may rupture and be fatal

at any time, or these ruptures may recur repeatedly. The feetus usually dies at first rupture, but may go to term. New membranes may form around it or it may be left free in abdominal cavity, and the placenta still retain its hold in the tube, and thus furnish nutrition to the feetus. It is then called abdominal pregnancy but was originally tubal. Rupture into the broad ligament—extra-peritoneal—is generally fatal to the child, but not so fatal to the mother or child as the other form. Nearly all full term feetuses are extra-peritoneal. The chorion and later the placenta enlarge their hold upon the mother's tissues or organs so as to receive enough blood to maintain life in the child.

The placenta most frequently fastens itself well down in the pelvis, but may be fastened to any of the tissues or organs of the pelvis or abdomen. The omentum, intestines, liver, spleen, any or all of these may be involved in the placental implanation.

It is this possibility that makes it necessary for us to be prepared for any emergency in every operative case we meet. In the extra-peritoneal variety the folds of the broad ligament are pushed apart. Uterus forced to one side and crowded up out of the pelvis, together with the peritoneum and all the contents of the pelvis and abdomen. Secondary hemorrhage may occur into abdominal cavity in this form of pregnancy, and results fatally or not according to amount of blood lost and location of rupture in its relation to the placenta.

Tubal abortion can only occur during the first eight weeks. Tubal rupture generally occurs from the third to twelfth week. Average is eight weeks.

In early rupture and death of the fœtus, the ovum and its surrounding membranes are usually absorbed.

When the fœtus lives to be more than three or four months old it may mummify, calcify, turn to adipose or suppurate. Fœtus never goes to term in the tube. May in the abdominal cavity, but it most frequently goes to term in the broad ligament.

DIAGNOSIS.

More depends upon early diagnosis in this than in any other condition which the obstetrician has to meet.

So I feel justified in going somewhat into detail regarding the history and symptoms of every case I see for the purpose of reaching an early diagnosis.

During the early weeks there are the usual signs of pregnancy, except there is apt to be more or less flow at time of first and second menstrural period. The patient generally concludes that she is pregnant and very often does not consult the doctor until collapsed from rupture. At this time there is a sudden, sharp pain on one side. Excruciating in character. Patient feels faint and dizzy. May lose consciousness. Vomits. Has cold, clammy sweats. Pulse rapid. Temperature below normal as a rule. More or less hemorrhage from the uterus. Due to separation of uterine decidua. Patient, and possibly doctor, concludes there has been a miscarriage. Some discharge may continue for weeks, containing shreds and clots often. If the microscope tells that there are no chorionic villi. miscarriage is ruled out, and diagnosis of ectopic gestation almost certain. Pelvic peritonitis develops rapidly as a rule. Ruptures recur occasionally.

RECAPITULATION.

Menstrural irregularity. Symptoms of pregnancy. Sudden sharp pain. Syncope and vomiting. Metorrhagia, and all these symptoms are preceded by a period of sterility as a rule.

Within the last five years so much has been done to clear up these cases that diagnosis before rupture is quite possible, and in the hands of experts the rule, provided they see the patient in time. This early diagnosis is so essential to the welfare of the patient that we may almost say her life depends upon it. This being true, I take the time, even at the risk of repetition, of enlarging some upon the early symptoms of tubal gestation.

First let me speak of the physical signs. Before rupture. Distended tube, with more of a boggy feel than in hydro or pyosalpinx. Uterus enlarged. Enlargement most marked in long diameter of uterus. Cervix soft. Os patulous.

Immediately after rupture. There is no distinct tumor. Sensation of fluid or indistinct doughy feel in pelvis. Especially in Douglas' pouch. Symptoms of internal hemorrhage. Rupture in broad ligament gives us hematoma. Blood clots

quickly, and is quite firm, because the broad ligament holds it firmly and the pressure is sufficient to cause firm clots and arrest the hemorrhage.

Three keynote symptoms I will repeat: 1, Pain, its character, location and manner of occurrence. 2. Irregularity rather than suppression of menses, and often accompanied by uterine decidua without the chorionic villi. 3, Small lump in the tube, size of the thumb and not adherent at first. This lump soon becomes tender and fixed by adhesions. These lumps are very vascular. Often pulsating under the finger. I always make it a point to obtain as full a statement as possible regarding the pain in the patient's own words. They all speak of it as excruciating in character, coming on in paroxysms, with intervals of freedom from pain. These attacks of pain are likely to come, two or possibly three weeks after menstruation. Generally in one groin, though they may be across the abdomen. Extending down one leg, or up to the epigastrium. Being so very severe as to cause profound systemic disturbances. The terrible pain often causing more shock than the hemorrhage. In fact shock may be very profound and little hemorrhage found at time of operation.

DIFFERENTIAL DIAGNOSIS.

It will require some care to distinguish ectopic pregnancy from the following: Before rupture physical signs are similar in this and the hydro or pyosalpinx. Before rupture in ectopic pregnancy there are the usual signs of pregnancy and these are not present in either of the other conditions. After rupture in ectopic pregnancy pulse is more frequent. Temperature subnormal (a rare combination) and the pain is very severe, but short and recurring. Loss of blood, or collapse very marked. Septic symptoms absent or slow in developing. In pyosalpinx, pulse is slow, and gradually increases in strength and rapidity. Pain lasts longer and is more steady but not so severe. No loss of blood internally or collapse present. Sepis manifested early and increases rapidly. It is sometimes difficult, from physical signs alone, to differentiate this from fibroid of ovary, or fibro-myoma. But the history will clear up all doubts. Fibroid is of slow growth. Much harder, and fibromyoma is more intimately connected with the uterus.

They may both be present, when the patient's condition is indeed serious. Ovarian cysts readily told by history and absence of pregnancy symptoms.

Hematocele is so nearly synonymous with ectopic pregnancy that I will not take time to discuss it further.

TREATMENT.

During the last few years, or I might perhaps better say, during the last two years, there has come such a change in the minds of the profession regarding the treatment of this condition that we are not justified in concluding that any fixed standard of procedure has yet been reached. At present and for sometime to come each physician will be more or less influenced by his personal predilections. Some will adopt the so-called expectant treatment. Others will try to kill the fœtus by electricity. While still others, those of a surgical turn, will advocate and practice surgical procedures in all. cases. These will in all cases resort to laparotomy or elytrotomy according to the location of the fœtus and placenta, or according to the bias of the operator for the vaginal or abdominal route. In my opinion, elytrotomy is applicable only in cases where the fœtus is dead. Or is impacted in the pelvis and we are pretty certain before operating that the placenta is attached high up in the pelvis or in the abdomen.

Even then all we can do is to remove the fœtus, drain through the vagina and allow the placenta and membranes to come away by degrees.

It is perhaps true that electricity is not as much used as formerly, but I still feel that before the death of the fœtus, which generally occurs at the time of rupture of the sac, there may be conditions or circumstances under which electricity should be used in preference to the knife. Ectopic gestation snould always be looked upon as a grave obstetric complication. One in which the life of the mother is in constant jeopardy. The chances for the child are so very remote as to hardly be taken into account. So our whole thought should be for the mother.

If the attending physician is not a skilled operator. If he is far removed from such help and there are no urgent symptoms he is justified in using electricity for the purpose of killing

the fœtus. This is allowable in the earlier months of gestation. Not later than the fourth month. The faradic current is the only one to be thought of. Place the negative electrode in the rectum or vagina. Whichever will bring the electrode the nearest to the sac. The positive pole with a large, flat electrode on the abdomen just over the sac. Allow the current to run five or ten minutes. Let the strength be regulated by the tolerance of the patient. Continue this daily until the sac begins to grow smaller. Then you may know the fœtus is dead, and the liquor amnii is being absorbed. We must not forget the fact that the electric current sometimes ruptures the sac, but by anticipating such a contingency we will be prepared to combat the resulting collapse, and tide the patient over the crisis.

LAPAROTOMY.

Before rupture the operation is comparatively easy for one accustomed to abdominal work. Simply tie ovarian artery at distal and proximal end of the tube, and take out the mass. If sac is not broken in removal the abdomen is closed without drainage. After rupture into abdominal cavity prepare to open the abdomen at once. If operation is imperative, it is demanded because of hemorrhage.

Should the pulse show any sign of improvement, wait until shock is over. When the patient has rallied from the shock it is best to operate as a rule. This must be done rapidly as the patient, at best, is not in a very good condition for such a serious operation. Enter the abdomen through a good, free opening and first seize and ligate the bleeding vessels, if any can be found. If not readily found, tie the ovarian artery, and then take time to clean out the blood clots and all the products of conception. Flush the cavity and as a rule leave in drainage. To tide the patient over the shock flush the cavity thoroughly with saline solution, and after the cavity is clean leave in some of the solution. Only a few days ago this expedient brought the pulse from forty, and very feeble, up to sixty-eight, full and strong, in two minutes in a patient upon whom I was operating.

In extra-peritoneal rupture the shock is not so great. Do not operate as a rule. Keep the patient quiet and apply cold

at first, and later apply heat. Fomentations of poppy heads have served me well in four cases. Have two sacks and change as often as need be to keep them hot and to control the pain. Absorption generally takes place in due time. If it does not there may be suppuration, caused by absorption of poisons from the intestinal canal. In this case drainage through the vagina is the best method of treatment. If hemorrhages recur laparotomy will be indicated.

We have thus far had in mind the treatment during the first four months of gestation. After this period the treatment embodies some different principles and will necessitate somewhat extended notice. Remember that in nearly all these cases the fœtus is extra-peritoneal. In all cases where operation is undertaken keep outside of the peritoneal cavity if possible. After the fourth month rupture is not so liable to occur. For by that time the placenta has secured such a firm hold that life can be maintained for the whole period of gestation. is easy as a rule to tell whether the child is alive. Fœtal heart sounds can generally be detected. And ballottement can generally be practiced. The foetal movements are quite distinct after the fifth month. These, together with the rapid increase in the size of the abdomen, are sufficient to make the diagnosis clear. At this stage we are brought face to face with a serious problem. Operation should not be lightly considered. because there are great probabilities of death from hemorrhage at this stage of development. Should the symptoms call for an operation it must be performed very rapidly. Make a large opening in the abdominal wall so as to be able to locate the placenta promptly. Do not disturb this. Open the sac and extract the foetus. Cleanse the sac. Stitch it to the abdominal wall and pack the sac cavity to control hemorrhage. Leaving the placenta to separate by degrees. Watch the placenta at each dressing, and if it can safely be done at any time, take it away in a mass. If it cannot so be removed, it must be allowed to come away by piecemeal. This is the usual mode of procedure, for the long standing abnormal conditions have produced such extensive deposits, and firm adhesions, that the products of conception cannot be removed at the time of operation. Of course remove sac and all if possible, but do

not take too many chances of fatal hemorrhage by disturbing the placenta. At the time of spurious labor the sac may be ruptured. If it is, our only hope rests in operation. Always be prepared to operate with but a moment's notice. Rupture here can be told at once and we must operate. If the sac does not rupture the fœtus will die in due time from the shock of labor. After its death the spurious labor ceases. With the death of the fœtus, we still have a serious condition to deal with, but all agree that it is best to watch the case closely, but not to operate unless urgent conditions demand it. These conditions will be peritonitis, or some form of blood poisoning.

Our reason for delay is that we expect the liquor amnii to be absorbed, and the circulation in the placenta gradually cut off. The operation can then be undertaken with reasonable assurance of success. If we find an opening in the sac and that the placenta still has more or less circulation, the operator must decide what course to pursue in the case in hand. Keeping ever in mind the immediate danger of hemorrhage on the one hand and the more remote but equally serious danger from sepsis, on the other, and choose the best plan for the case in hand.

There is a great difference of opinion as to the best course to take after the death of the fœtus, and all immediate danger of infection I as passed. The weight of authority is undoubtedly in favor of operation, and not trusting to nature to keep all the organs and tissues in harmless state. I have had no personal experience in cases of long retained products of ectopic gestation.

Prof. James C. Wood, of Cleveland, Ohio, has an excellent article in the first issue of the Homeopathic Journal of Surgery. He therein gives the history of an exceedingly interesting case where he successfully removed a lithopedian of years standing.

It is always best to remove these feetal remains by laparotomy no matter what condition they may be in, as their presence is always a menace to the health and life of the parent.

Numerous cases are on record where the products of conception have excited suppuration, resulting in long periods of ill health, or perhaps death, many months, or even years, after the death of the foctus.

Since reading Lawson Tait's famous article some thirteen years ago I have had eleven undoubted cases of ectopic gestation all told. Before then, I presume, I had cases but did not recognize them. The following case is chosen because of its peculiar features and special interest.

Mrs. B., aged thirty-four years, was admitted to the Homeopathic Hospital of Michigan University at Ann Arbor, March 10, 1898. Her history, briefly outlined, is as follows:

She was married in February, 1897. Her health had been very poor for several years. Menses irregular, scanty, and very painful all these years. Late in November, 1897, nine months after marriage, she was taken with a severe attack of what was diagnosed at the time as gastritis. In a few days the fever subsided and she had all the usual signs of pregnancy. The stomach was also unusually irritable. This condition continued until in January, 1898, when she was suddenly taken with very severe pain in the lower abdomen, and this could only be controlled by morphine. After these pains had continued for a week or so, during which time she had often been so low that they thought her dead, she began to flow quite freely and passed a mass of blood clots and membranes. The attendants concluded that she had aborted. But it was evidently the uterine decidua of ectopic gestation.

She then rallied a little and was able to take a little food, and could, with the greatest care, be turned a little in bed. Temperature was below normal for the first day and 101° to 102° for two weeks.

These attacks recurred about every two weeks, each being less painful, but leaving her weaker until about the first of March. She then rallied a little, and on the tenth of March was taken to our hospital for the purpose of having a large ovarian tumor removed, as they said to us. She was nearly moribund when she entered the hospital, and it required the most watchful care for several days to keep her alive. When she had rallied a little I made a careful manual examination. The patient was too weak to take chloroform. I found a mass firmly imbedded in the right side of the pelvis. This was about two and a half inches thick, four and a half inches wide and twelve inches long. This was firmly fastened to the right

side and part of pelvis. This mass was very firm but not tender. After obtaining a careful history of the case and repeated examinations, I diagnosed ectopic gestation, and made all arrangements to operate as soon as patient was strong enough. She was very weak indeed. At this time weighed but sixtyfour pounds. Weighed one hundred and seven pounds when. taken sick in November. She really looked more like a corpse than a living woman. This examination was made on the thirteenth of March. On the fourteenth she had another collapse. The relapses occurred about every two days for over two weeks, so that there was not enough gain in strength to justify operation. Since entering the hospital she had been taking kali iodide and china internally and poppy fomentations were applied externally. Early in April she had gained enough to make it safe to give chloroform, which was done and a thorough examination made. Very much to my surprise, I found the growth quite a good deal smaller. Of course, I felt encouraged at the outlook and decided to give nature time to absorb the mass of blood clots and membranes, holding myself in readiness to operate at any moment if conditions demanded it. Continued the iodide of potash, with an occasional dose of hydrastis for the stomach trouble. At the present writing (June 18th) the mass is all absorbed except a small lump at the fimbriated extremity of the tube. This is not tender but quite hard. Is growing smaller gradually. If it does not continue to do well I shall remove it through the abdomen. Patient is now menstruating with less pain than ever in her life, and more natural in quantity and character. Has gained twenty pounds in weight, looks, feels, and is much better in every way. An important factor in the rapid absorption of the deposit, as I consider it, was the local treatment I gave during the months of April, May and June.

This consisted mainly in the application of iodine compound to the endometrium, and the placing of vaginal wool tampon saturated with a mixture of glycerine, calendula, geranium and carbolic acid. This treatment was given every third or fourth day. Of course the uterus was well dilated and cleaned out at each treatment. The uterine walls were so soft and friable that I felt it was safer to swab out the cavity with

iodoform gauze rather than use the curette. Copious hot vaginal douches were given daily.

Let us draw a few conclusions from this case. With proper care the correct diagnosis could readily have been made out before the time of rupture and an operation could have been safely performed. At the time of the first rupture was also a good time to operate.

When she entered the hospital an operation was not to be thought of as at all safe. Our only course was to keep the patient alive with stimulants, given hypodermically until nature could come to our aid. This she did in a few days. The rupture occurred so early in gestation that all the products of the conception are absorbed, and in a few weeks, with proper care, this woman will be perfectly well.

Do not for a moment look upon this case as being my idea of the proper treatment for ectopic gestation. I have reported it because it is out of the ordinary run of cases, and yet any of you are liable to meet such cases, and my experience may be of value to you.



LINGERING LABOR IN THE FIRST STAGE: ITS CAUSES AND TREATMENT.

BY L. L. DANFORTH, M.D., NEW YORK CITY.

Read before the American Institute of Homeopathy, June, 1898.

Another year has passed away and we are gathered here in this obstetrical section of our national society for the purpose of increasing our knowledge, enlarging our views, and broadening our conceptions of the dignity of our high calling by personal contact with our fellows; of giving and receiving from the great store-house of personally acquired experience that which will enable us to return to our chosen fields of work in the hope that we may attain to a higher standard of success than we have ever reached before.

I believe that this is the motive which has prompted each member of this Society as he has journeyed hither, and I trust that in no wise will he be disappointed in this endeavor. I think we are to be congratulated on being able to assemble here at a time and in an age when everything relating to our profession has reached a pinnacle of absorbing interest and of the highest good to mankind; but it would be the height of folly to fold our hands and cease our efforts, for we have much yet to learn if we would keep abreast of this rapidly advancing age, an age in which the future scientific interest, practical extension and proportionate beneficence of our science and art seem to be unlimited.

We are here, fellow members, to discuss topics relating to the special department of midwifery. I hope to hold your interest for a brief period by referring to a topic which directly concerns the daily routine of professional life in promoting the comfort and welfare of our patients, and is therefore eminently worthy of your distinguished consideration. I refer to "Lingering Labor in the First Stage: Its Causes and Treatment." I shall endeavor to be as brief as possible, even dogmatic in discussing questions which to be fully studied would require infinitely more time than I have at my disposal. I can do little more than merely indicate some of the topics which naturally suggest themselves for consideration. Very likely

these will not meet with general acceptance, but they will at least form a text for debate and may possibly elicit a valuable expression of opinion from the learned physicians present, who must have had a large practical experience in actual midwifery work. I shall classify the causes of lingering labor in the first stage as follows:

- 1st. A rigid and undilated cervix.
- 2d. Slight disproportion between the head of the child and pelvic inlet whether due to actual contraction of the conjugate, or to the relatively large size of the child's head.
- 3d. Malposition and malpresentation of the presenting part.
 - 4th. Uterine inertia from inherent weakness of the womb.

In discussing the first division of the subject, viz., the rigid cervix, it may be stated almost as an axiom, that there is as a rule no real obstacle to delivery in the state of the cervix itself. This part of the uterus will dilate readily enough provided the expulsive forces be properly acting, and in dealing with this condition our first object will be to ascertain, and if possible to remove the condition which is interfering with the normal progress of the case. This can only be done by a careful examination of all the factors entering into the solution of the mechanical problem involved. I have stated that as a rule the cervix will dilate properly provided the expulsive powers be acting efficiently. In making this broad statement I am conscious of the fact that sometimes non-dilation is due to structural causes, such as malignant indurations or cicatrices from former injuries or operations; but these conditions are extremely rare. When they exist they are easily discovered and the treatment is at once obvious. In the consideration of causes I refer especially to the difficulty frequently met with arising from non-dilation caused by inertia or by irregular or cramp-like pains; also premature rupture of the membranes (or what is practically equivalent to premature rupture), scantiness of the liquor amnii with perhaps a thick tough inelastic sac; or again, and not less important, non-dilatation arising from excessive sensibility (hyperesthesia) of the dilating structures, a condition which is but the local expression of a generally hypersensitive state of the whole system. It is quite

true that these conditions in themselves are not serious obstacles to the ultimate termination of the first stage of labor without the intervention of any means that our art can supply. But that they are serious in the sense that they often greatly prolong the first stage of labor and add materially to the painfulness of the dilatation no one with practical experience will deny. I cannot agree with the old dictum that protraction of the first stage is of no importance, provided the membranes are unruptured, or that the suffering which attends the first stage is of little consequence. It was formerly stated by obstetric writers that labor is not to be considered as even tedious unless more than twenty-four hours have elapsed, and furthermore that no matter how long the delay we are not justified in interfering unless we find symptoms of exhaustion resulting.

In Blundell's classical work (1842) we are told that "In lingering labors generally, unless there are symptoms of danger, the less you interfere the better, for a meddlesome midwifery is bad; and if the protraction of the delivery be the only inconvenience which the patient suffers, and there are no convulsions, no floodings, nor well-marked signs of collapse to excite alarm, it is scarcely necessary the accoucheur should interfere at all."

Such advice as this is very correct provided all the processes concerned in the physiological dilatation of the cervix are performed in a perfectly normal manner.

Such a first stage even though prolonged over a space of ten, or twelve, or fifteen hours, while fatiguing and more or less exhausting does not call for special treatment. But the question which it is desired should be brought out clearly is this: shall a first stage be allowed to drag on hour after hour when the physiological conditions concerned in the act are not being properly performed? Is the mere fact that the membranes are as yet unruptured and presumably, therefore, no danger threatening the child, a sufficient reason why the accoucheur should stand idly by with folded hands doing nothing hour after hour until symptoms of mischief have actually arisen? Is not the mere wear and tear of a labor lasting twenty-four hours or more in itself a serious thing, and is it

not merciful and wise to adopt such means as will tend to minimize the pain, shorten the duration of the first stage of labor and thus conserve the strength of the patient that she may be the better prepared for the more arduous efforts of the second stage, as well as predisposed thereby to a more rapid and comfortable convalescense?

It is important to bear in mind the fact that although pain is the usual and necessary accompaniment of labor and is in a certain sense an important physiological factor, it is in its essence pathological. Pain during labor depends mainly upon two conditions; first the susceptibility of the patient, and, second, the state of the expelling and resisting forces. If susceptibility is great and the expelling forces urgent, at the same time that the resistence is nearly equal to the expelling power, the dilatation of the cervix and the advance of the presenting part will not only be temporarily checked but excruciating pain will become an added factor of the utmost gravity.

Through reflex influences, partial or complete inhibition of the nerves which send their motor impulses to the muscular fibres of the uterus results, and uterine activity is either greatly modified or ceases altogether.

Herein lies the justification of my remarks concerning the adoption of such mechanical and medicinal means as have for their object the shortening of the first stage of labor when unduly prolonged, and the mitigation of pain when this becomes severe and exhausting.

It is a matter of common experience that homeopathic remedies accurately administered will increase weak pains, regulate spasmodic pains and otherwise so harmonize the forces of nature that labor will progress in a natural manner. But it is not my purpose to refer to this part of the subject, and so far as purely oxytoxic drugs are concerned, they will be considered by another writer at this meeting.

The class of cases to which my comments especially apply are those in which nature is embarrassed by some physical obstacle and hence ceases her efforts, partially or wholly, until the fault is rectified spontaneously or by art.

Many cases of lingering and painful labor may be relieved by the application of a few common sense rules to the management of the membranes.

Extremely painful labor is often observed when the head of the child is well engaged in the cavity of the true pelvis (as in primiparæ) when the labor begins. The head will then be found distending to the utmost the lower segment of the womb, putting all the tissues on the stretch until they are so thin and tightly drawn as to be scarcely distinguishable from the scalp of the child, the os itself being directed backward toward the hollow of the sacrum, and so high up as to be felt with difficulty. In these cases the force of the uterine contractions is directed in a line anterior to the mouth of the womb and is therefore spent in fruitless and painful efforts in still further distending the thinned and sensitive anterior uterine wall instead of the os, as would be the case under more natural conditions. The head by its size and low position also acts as a ball-valve and prevents the formation of an efficient bag of waters.

If, under these circumstances, the head be pushed up in the intervals between pains an opportunity will be afforded for the descent of the liquor-amnii and pressure on the sensitive cervix will in a great measure be removed; at the same time the finger should be placed in the os, and its position changed by drawing it forward so that the direction of the uterine driving force and the center of the os will be on the same pelvic axis. You have thus created an efficient bag of waters, rendered effectual the driving force, and by so doing have transformed abnormal into normal conditions, all of which will facilitate dilatation and lessen pain.

In some cases the uterus will fail to act properly owing to overdistension, as in time-pregnancies and polyhydramnois. The first stage may be greatly delayed in consequence of this condition alone. If, on careful examination, it be found that the cervix is dilatable, and all that is required is more efficient uterine action, rupture of the sac in the interval between pains, at a point as remote as possible from the center of the os, will prove a very efficient means of increasing uterine action and dilating the cervix.

In an occasional case the first stage is prolonged and rendered needlessly painful by a small amount of "fore waters," and a tough inelastic sac, or at least a sac which has never become thinned, because it has never been "put upon the stretch," so to speak, by the force of the uterine contractions. When this state exists great good will be accomplished by lifting up the head, allowing the waters to descend, thus creating a fuller sac, and, perhaps, at an opportune time rupturing the sac, if the cervix possesses a fair degree of dilatability. Amongst mechanical processes used in the treatment of undilated os, manual dilatation with the finger, long held a prominent place and at one time in the history of midwifery was the subject of much acrimonious discussion, having been recommended by Smellie, Burns, Gooch and other prominent obstetricians in England, and as strongly denounced by others, particularly by Denman, who calls it "an abominable practice."

Whatever may be the adverse comments of some practitioners, I am convinced that it is a sound, practical observation, and promotes dilatation to a remarkable degree, if the finger be swept around the inner circle of the os, and at the same time the os stretched to a moderate degree.

Whether this manoeuvre acts by separating adhesions which retard dilatation or by stimulating the nerve supply of the uterine muscles by irritation of those of the os, I am unable to say, though it would seem that the latter theory were the more probable. When the head is low down in the pelvis, the os soft and unrelaxed and membranes ruptured, it is good practice to push, as it were, the os over the head, since the progress of the case is thereby often expedited. It requires some judgment and practical experience as to the proper cases in which this expedient is to be used. The procedure is capable of much abuse, and should be employed only by skilful and careful hands. Pushing up the swollen anterior lip when impacted between the head and pubes, is also not only legitimate, but essential, to save injury to the os. gentle pressure of the finger is obviously much less likely to be harmful than the long continued bruising to which the uterine structures would otherwise be subjected.

Now as to the control of pain when this is a factor per se in the first stage of labor. All practical obstetricians are aware of the great and prolonged suffering which often attends the first stage, even when we do all we can by means of homeopathic remedies and local means for its relief.

How often do we observe a case in which apparently all the conditions are favorable; good uterine contraction at regular intervals; a normal sac developing surely though slowly as it performs its functions in dilating the cervix, and yet the pain which the patient suffers becomes almost intolerable and proportionately exhausting!

Again, when the bag of waters ruptures prematurely and the head of the child presses on the sensitive cervical tissues, how painful is the process and how tedious as it drags on hour after hour!

Often the os will be found high up, so as to be reached with difficulty, slightly patulous and rigid, thus presenting a condition which almost surely forebodes a slow, tedious, and painful labor. In such conditions the imperative duty of the accoucheur is to relieve pain, relax the tissues, and lessen the spasmodic uterine action, all of which are recognized causes of non-dilatation of the cervix. This may be done by the use of a remedy which is an analogue of chloroform, viz: chloral, the use of which in this connection was first suggested by W. S. Playfair, of London, in 1874, and has since been used very generally by physicians of the "old school," though very little, I believe, by homeopathic physicians. But why should it not be? Most of us at the present time employ and few decry the use of chloroform in the second stage of labor, though all admit that it possesses certain disadvantages when given over-freely, since it distinctly retards labor by lessening uterine action and thereby predisposes to uterine inertia. Choral has no such disadvantages, and while not so anesthetic as chloroform, it is distinctly hypnotic and moreover does not in any way derange the natural processes of labor; it does not affect the motor nerves nor impair the contraction of muscle, and although it does not directly suspend the functions of the sensory nerves, it relieves certain kinds of pain due to irregular or over-action of unstriped muscular fibres. (Bartholow.) Hence its utility as a remedy for the relief of the so-called "nagging pains" of the first stage of labor. Playfair says: "Since using chloral I have practically never had any trouble

from the rigid cervix which formerly used to give so much worry. Under the use of this agent the pains become longer, steadier and more efficient; the patient falls into a somnolent condition, dozing quietly between the pains, which are not lessened or annulled, as is the case when chloroform is inhaled freely; and above all the wild state of excitement which is so frequent in this class of labor is calmed and soothed, to the infinite relief of patient and practitioners." Schroeder says: "Chloral has been given in tardy and exhausting labors. After an hour's sleep, on awakening, the labor was very rapidly terminated by powerful pains. We have also observed that by the use of chloral in cases where the uterine action was very painful without being efficacious, the labor assumed an instantaneously rapid course, although the intervals between the pains had considerably increased in duration." Atkinson, of Philadelphia, says: "It would appear that even while chloral produces a calm, refreshing sleep it does not by any means entirely check the progress of labor when this act has commenced. For it is invariably found that dilatation has gone forward, and generally, so completely is this accomplished, that on the patient awakening, a few quick pains will often complete the delivery. I regard the use of this remedy as producing results similar to those of an anesthetic in surgery, and therefore similarly indicated. While it relieves to a marked degree the pains of travail, it measurably contributes to a safe and speedy convalescence." To accomplish these beneficent results it is not necessary to administer doses of any unsafe amount. Fifteen grains, repeated in twenty minutes either by mouth or rectum, is generally sufficient to produce an effect lasting over several hours. Possibly a third dose may occasionally be required, but never more.

I would call your attention next to another question, the second in our classification, viz.: Delayed first stage from slight disproportion between the head of the child and the pelvic inlet, whether due to the contraction of the conjugate, or to the relatively large size of the child's head.

The first stage of labor is often unduly prolonged by causes which are not apparent or even suspected at the beginning of labor. Among the most important of these is the one I

have just presented. By what indications are we able to recognize such disproportion and how are we to proceed when the exact nature of the difficulty is recognized? No greater problem confronts the obstetrician than the determination of this question, since upon its correct solution may depend the life of the child and perhaps of the mother as well.

Pronounced pelvic deformity of a high degree at once arrests the attention of the obstetrician and the appropriate procedure is apparent without much difficulty. But not so when slight disproportion exists, since to the casual investigation all appears normal, and it is not until the labor has dragged on its wearving course past the usual time for the first stage to be completed that any abnormal condition is even suspected. Whenever the head of the child does not engage so that the parietal protuberances are apposed to the symphysis and the promontory respectively, in other words when the head is resting on the pelvic brim, but not engaged in it, after the continuance of strong labor pains for a period of three or four hours, I would urge that no more time be wasted in expectancy, but that an effort be made at once to ascertain the cause of the delay. I have known cases where this state of things was allowed to drag on twenty-four hours and more, even until the waters had drained away, the patient herself had become utterly exhausted, and the life of the child jeopardized, if not actually lost, before any attempt was made to ascertain the nature of the difficulty. There is one indication at least whereby we may know whether the bag of waters is being influenced by the uterine contractions and that is by observing whether or not the cervix is subject to tension at the height of the "pain." Before the rupture of the membranes, the uterine contraction at its acme will cause the sac to bulge somewhat; but in spite of this the cervix often dilates slowly or not at all, and remains about the same hour after hour; thus showing that there is some impediment to proper uterine action either of the nature of over-distension, malpresentation, or retention of the head above the brim from relative disproportion. But premature rupture of the membranes oftener happens than delayed rupture under these circumstances because the presenting part does not fill the os uteri and shut off the "fore waters" from the general intra-uterine pressure. In such a case after rupture of the membranes the presenting part does not come into the os uteri to dilate it, and it is therefore uninfluenced by the pressure and is only very slowly and imperfectly influenced by the uterine contraction; the cervix therefore hangs "fringe-like" below the presenting head. Having by these indications arrived at the conclusion that there is some reason why the head does not engage and the first stage of labor come to its natural termination, the next duty is to ascertain the cause of the delay. This requires a careful internal examination to determine the exact relation of the head to the pelvic inlet, and involves also some observations on pelvimetry. I cannot refrain from saving a few words on the subject of pelvimetry, which as a part of obstetrical study has received far less attention than its merits deserve. The educated obstetrician of the future will be expected to make such observations, by means of his hand, and the pelvimeter, as will enable him to determine with sufficient accuracy for all practical purposes, the dimensions of the pelvic inlet, to say whether it is the conjugate alone, or all the diameters of the brim which are diminished, and approximately the degree of the contraction as well as the relation which the contained body—the child—bears to the passage which it is by nature intended to pass through. I express the hope that obstetricians will pay more attention to this subject in the future, since by so doing they will be able to decide upon the relative merits of the different operations which often come into intimate and perplexing competition with each other.

In delayed first stage when an obstacle exists to natural engagement of the head two measures are open to us—if it is decided that the natural forces are unequal to the task of delivery, viz.: forceps and version. I will define the indications for each procedure when the head is at the superior strait.

First the Forceps.—As preliminary it must be determined that the conjugate measure three (3) inches or more; that the child is alive; and the uterine contractions are present. Then the position of the head must be accurately made out; if it is lying with its long diameter transverse, the anterior fontanelle

as low down as the posterior, and, as Litzman pointed out as an induction from clinical experience, if the sagittal suture is nearer the promontory than the symphysis, and not less than three-quarters of an inch from the former, it is fair to infer that the head has so far engaged that forceps delivery will be comparatively easy.

Herman (Difficult Labor) has also emphasized the fact that when the sagittal suture is in the position described it is good evidence that the head is entering the brim with the smallest possible diameter opposed to the conjugate. If forceps be used and traction made as nearly as possible in the axis of the pelvic inlet, the probability is that the posterior parietal bone will slip rather suddenly past the promontory, and the subsequent steps in the delivery will be easy.

Indications for Version.—If, instead of finding the head in the position described, the sagittal suture is discovered nearer the pubes than the promontory, or if the pelvis is not contracted to a high degree, yet the head is so large that its greatest diameter is high above the brim, then (the cervix being fully dilated either naturally or manually) turn and bring down a foot.

It is not my intention to enter into the comparative merits of these two operations which so frequently come into competition with each other, but I cannot close this part of my subject without emphasizing a few points which seem to me essential in dealing with any case of delayed labor in the first stage when the head is presenting. The rules for performing either the high forceps operation or version may be ever so clearly defined in one's mind, but these rules will be capable of very imperfect application unless the physician has an accurate knowledge of the position of the posterior fontanelle, and its exact relation to some determinate point on the maternal pelvis. This essential preliminary information is difficult to obtain with accuracy unless the patient is placed under an anesthetic; when this is done the hand in the pelvis can ascertain the exact location of the posterior fontanelle, the position of the parietal protuberances with relation to the promontory and the symphysis and also the direction of the sagittal suture as well as its approximate distance from

the promontory. These facts should all be made out without the least shadow of a doubt, since by so doing only can one be sure of the diagnosis in all its aspects, and be able to select intelligently and accurately the appropriate operation for the case in hand.

Malposition of the Presenting Part.—The influence of various modifications of head presentations, and of other absolutely normal presentations in modifying the first stage of labor, requires no further comment than to insist upon an accurate diagnosis of the exact presentation at the earliest possible moment since successful treatment will depend upon the solution of this problem. I need but refer to the various malpositions which are sometimes observed. Among the various anomalies of position the non-descent of the head from impingement on the pelvic brim is sometimes met with. This is the result in most cases of disproportion between the head and the pelvis. When associated with delayed rupture of the membranes the first stage of labor may be greatly prolonged, but the delay is not necessarily harmful unless the patient is deprived of rest from long continuance of the pains.

The malposition is sometimes spontaneously rectified by the rupture of the sac, an increase of the uterine action and engagement of the head.

If the cervix is soft and dilatable, we may imitate nature and rupture the membranes which will correct the difficulty by letting the head down so that it will distend the cervix and thus accelerate the force and frequency of the contractions.

The first stage of labor may be prolonged by malposition of the uterus itself which conduces by misdirection of the driving force to malpresentations of various kinds and degrees, but pre-eminently to those of the face, the brow, or the sinciput.

The early recognition of the cause of the vicious presentation and its correction by changing the axis of the uterus so that it will conform to the axis of the pelvic inlet—will be followed by good results.

The presentation of the head with its occiptal portion toward the back of the mother's pelvis, the high occipito-posterior presentation is oftener a cause of prolonged and painful first stage than is ordinarily suspected. If delay really becomes a serious factor, in consequence of prolonged pain, the hand should be inserted into the cavity of the pelvis, and the fontanelles accurately located.

If the case prove to be an occipito-posterior presentation and the cervix dilated or dilatable, it is good practice to rupture the sac if this has not already taken place, and at the same time make an attempt to rotate the occiput to the front. This may be accomplished by the use of the external hand which is used to rotate the anterior shoulder to the left and backward. while the hand inside is employed in the endeavor to rotate the occiput toward the right and to the front. The correction of transverse presentations into the more favorable and absolutely essential head or breach presentation needs only to be mentioned to be appreciated. Likewise the fact that breach presentations predispose to a slow first stage, and require no treatment, except that which conduces to rest and sleep when the dilating stage is tediously prolonged. subject of malposition and malpresentation is very closely associated with the last division of my subject, viz.: uterine inertia.

Given the case of an ordinary, average, normal woman, one fairly well built and her organism in normal condition, if inertia is present, whether primary or secondary, in a great majority of such cases it will be found on examination that the lack of action on the part of the womb is due to malposition or malpresentation of the fœtal body to the maternal pelvis. Nature's forces are so well adjusted to the task which she has set herself to fulfill that she revolts and finally absolutely refuses to make any further attempts to force the presenting part into the pelvis at an angle and under circumstances where it is mechanically impossible and a violation of the laws of physics.

Enough has been said on this phase of our subject. I would like to ask your indulgence for a few moments longer to say a few words upon primary inertia from inherent weakness of the womb, its cause and a possible danger attending this condition. I refer to fatty infiltration of the muscular tissues of the uterus. Bossi, of Novara, Italy, has recently published

(Annali di Obstet. E. Gin., December, 1896.) the results of his researches in uteri for fatty degeneration during gravidity. Three cases were studied.

The first was a primipara in the eighth month of gestation with a fibromyoma of the anterior wall of the uterus which owing to its size and location caused such distressing symptoms that a cæsarean section was performed with favorable results to the mother and child, the uterus being entirely removed. Some portions were taken from various portions of the posterior wall of the uterus which showed no trace of fibro-myoma.

The second was a woman at term whose severe hemorrhage from rupture of the uterus required immediate removal of the uterus by vagina.

The third was that of a uterus removed by cæsarean section during the last month of gestation for osteomalacia of the pelvis.

The historical results of examination of small subdivided pieces made it once clear that in all three uteri the fasciæ of the smooth muscular fibers had undergone fatty degeneration, adipose fragments in the muscular fibro-cells were prominent on account of their intensely black coloration. Careful study showed all the phases of the process from the initial stage to complete destruction of the muscular fibers. In the conclusion of his paper, based on his examination, Bossi asks the following question: "Could not this process of fatty infiltration, if far advanced and diffused, account for many cases of uterine inertia?"

In answer to the theoretical question I would state that clinical experience in my own practice and reports of cases from reliable sources, tends to an affirmative answer to the query. I believe that fatty infiltration of the muscular fibers of the gravid uterus does tend to primary inertia. I have seen several cases when I had reason to believe there was a fatty condition of the uterus and in every instance there was inertia with a prolonged first stage. These patients were abnormally fat, the pelvis lined with fat, they were easily exhausted and every one required operative interference in order to deliver.

In current literature during the past year I have seen reports

of cases which were characterized by uterine inertia, which were not only troublesome on account of this complication, but which terminated in rupture of the uterus, every one occurring without the classical symptoms of rupture; there was no tumultuous pain, no sudden cessation of labor, recession of the presenting part, or collapse.

In cases presenting such conditions as I have described, flabbiness, excessive deposit of fat, uterine inertia, whether primary or secondary, and prolonged labor, it would be difficult to decide what to do. Whether to leave the case to nature or deliver?

I shall not attempt to settle the question as to the proper course to pursue, and will close with the thought that in all cases where the inertia is primary in flabby fat subjects prolonged labor should be guarded against, and the liability to uterine rupture borne in mind.



RACHITIS.

BY W. A. HUMPHREY, M.D.

Read before the American Institute of Homeopathy, June, 1898.

Rachitis is a disease of infancy and early childlife dependent upon mal-nutrition and mal-assimilation, the results of which are manifested in the bones and bone-producing tissues, supplemented by certain phenomena in the vegetative, nervous and muscular systems.

CAUSATION.

The causes contributing to the development of rachitis are numerous. Children born of unhealthy parentage, upon whose constitutions are implanted the tubercular or syphilitic taint; whose nutrition is impaired from disease or from overwork and care, or who are underfed, are productive of unhealthy progeny, in whom disease finds ready soil for its development. Mothers who nurse their children through the second summer, or whose nurse is in any way impoverished from ill-health or defective nutrition or assimilation, or bad hygienic surroundings, are not proper individuals to assume the responsibility of maternity. The nutrition furnished to the child and its proper assimilation by it is, perhaps, the most important consideration in the production of this malady, yet the lack of proper food is not alone sufficient causation for its production, since children of all classes of parentage, whether rich or poor, and even when well fed, are by no means immune. It is true that babies nursed at the breast during the first twelve months are less often attacked than those brought up by hand, and when they are attacked the type of disease is much less severe. Overfeeding with the best-selected diet, to say nothing of unwholesome food, such as starch, potatoes, pork and raw fruits, relatively to the age of the child, tend to irritative dyspepsia and indirectly to defective and irregular bone development. The fact that many properly fed and properly clad children of healthy parents develop rickets, while many improperly fed and improperly clad and of unhealthy parentage do not develop it, is still a causative factor beyond these which must be made operative to render them active in the development of the

disease. Lack of fresh air, sunlight and exercise, and the crowding together in unwholesome quarters in tenement districts of large cities, with persistent lack of animal fat and the proper proportion of saline ingredients in the food, adding to these the exposure to variations in temperature consequent upon such surroundings, make the development of rachitis easy.

ANATOMICAL CHANGES.

Rickets usually shows itself during the first two years of life, commencing often in utero. "The most characteristic change is the increased formation of vessels in bone, which is apparent even in slight attacks" (Keating). The cartilaginous canals are widened, the vessels within the canal also enlarge and eventually deposit bone-making material in the cartilage, which is deposited in an irregular manner, contrary to the regular straight lines of normal calcification in cartilage. Kassowitz says: "Much of the organic part of the bone has been laid down without the lime. The increased vascularization results in the deposit of loose, spongy tissue in the vicinity of the vessels which is deficient in lime and which continues until the end of the developmental stage. When involution begins, the vessels diminish in size, and around them is deposited new bone. The spongy tissue is hardened by a condensing osteitis." The poverty of lime found in rickets bone is not conclusive evidence of its causative influence in producing the disease, since it is impossible to reduce the supply in the food to the proportion found in the deposits of extreme cases of rickets, and since its administration alone as a therapeutic agent fails to prove curative. The red corpuscles are always below normal, as well as the hemoglobin. leucocytes are at variance with the normal. The specific gravity of the blood is below normal.

Thomas Barlow, reviewing the facts disclosed by a study of the morbid anatomy and etiology, concludes "that proliferation of cartilage with the associated increased vascularization must be regarded as pathonomis of rickets, softening of bone being a more variable and less distinctive feature; that histologically it is impossible to distinguish such a condition from that met with in the early stages of an ordinary inflammation; that we have to deal with an irritative overgrowth of ostogenetic tissue, and that this, and not deprivation of lime, is the primary factor in the disease. Whatever the irritant causing the overgrowth, it is quite certain that it is easily developed in early life. For if one fact stands out more prominently than another in the pathology of rickets it is this: that almost any injurious influence brought to bear on a child during the period of most active growth tends to produce it: a chill to the surface, inhalation of noxious gases, assimilation of ill-digested fluids, etc., may develop an irritant in the blood which acts on the tender walls of the young vessels in the growing parts of the bone."

SYMPTOMS.

Among the early manifestations are the beads, or "rickety rosary," at the juncture of the ribs with the cartilage. These may be the only distinctive symptoms of the disease, and vet they are of such importance as to warrant a diagnosis. A child with a previously healthy record who becomes irritable, develops a diarrhea accompanied by convulsions should place the attendant upon guard, and a careful search should be made for beads upon the ribs. The larger number of these cases end in rickets. The percentage of children subject to convulsions who develop rickets is very large, especially those who have laryngismus stridulus, which indeed is so often based upon a racnitic origin that it always is well to regard every case of it with suspicion as to its causation. The aspect of the head is altered. The anterior-posterior diameter is elongated, the outline is polygonal in contrast with the circular outline of the hydrocephalic. In others lack of symmetry prevails. bones are thin, often crackling like paper under the accoucheur's hand at birth. Generally speaking, the child is emaciated, yet he opposite condition is occasionally observed and we have fat rickets, which is easily overlooked in its earlier stages unless we search closely for the beads; their presence together with laryngeal spasms at night warrant the diagnosis. As the disease progresses and the strength wanes the ribs and spine project packward in a rounded manner in contrast to the angular projection in kyphosis from caries. Lateral curvature often finds its cause in rickets. The general weakness of the body, allowing it to incline in any direction which may have an irritation, such as pleurisy, as a starting point.

The aspect of the limbs is most markedly altered at the wrists, the radius and ulna being larger than normal at the juncture area of the epiphysis, which also becomes enlarged. The changes in the other long bones are similar, depending largely upon the severity of the attack. If it be severe and occur early, before the child walks, the bones of the arms will be bent, owing to the weight of the body being supported upon the palms of the hands as the child sits. The same is true of the lower limbs, when the child walks, being greatest in the direction of the superimposed weight. A tenderness of the limbs is a prominent symptom later on, which is, no doubt, a bone tenderness, though it may be shared by the poorly nourished muscles. Fever is absent in some and present in others, especially when there are present catarrhal conditions, which often complicate the disease, manifested in bronchial or intestinal irritation.

Rickets is by no means a rare disease. The general practitioner in smaller towns sees an occasional case only, while in larger centers of population it is classed as one of the frequent diseases. Some hospital records show the percentage to be as high as thirty. Rickets of itself is rarely fatal, but fatalities are frequent from complications. Where recovery occurs only minor deformities disappear, while grave ones persist and stamp the victim as having been rachitic the rest of his life time.



DIAGNOSIS OF TUBERCULOSIS IN CHILDREN.* FRITZ C. ASKENSTEDT, M.D.

Since, in disease, there is a certain uniformity in the appearance and course of its symptoms which enables us to recognize specific causes and pathological changes often amenable to rational methods of treatment, medical diagnosis becomes an essential element for the intelligent treatment of the sick. With the evidence fast accumulating that during its early manifestations tuberculosis is not the incurable malady it was formerly considered to be, in no affection, perhaps, is an early diagnosis of greater importance than in the primary stages of this disease.

It has long been an observed fact that where confined to parts permitting removal, tuberculosis can often be wholly eradicated by surgical measures, while experience and postmortem examinations of patients dead with other diseases amply demonstrate the curability of extensive tubucular lesions of internal organs as well. Dr. Ditweiler, of Falkenstein, Germany, reported, some years ago, the unprecedented success of curing 36 per cent of all patients admitted with pulmonary tuberculosis, in all stages of the disease, to his institution, where hygienic measures, combined with a favorable climate, were the only means employed. Cures of cases of tubercular meningitis, confirmed by post-mortem examinations after death from other causes, have been authentically reported by such men as Riliet and Lebert, and the list would, no doubt, be considerably extended could a positive diagnosis be readily made during life. Recovery of a case of tubercular spinal meningitis was reported in 1895, in the Am. Jour. Med. Science, by Dr. Freyhan, who confirmed his diagnosis by an exploratory puncture of the spine, demonstrating the presence of the bacilli.

Before presenting a synopsis of differential diagnosis of tuberculosis in children, let us determine what peculiar element characterizes it as a specific disease. Until bacteriology revealed the presence of the bacillus tuberculosis in the miliary

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tubercles the exact relation tuberculosis bore to allied diseases was not closely defined. In histological structure the tissue affected does not present sufficiently uniform changes to identify the disease, for the presence of tubercles with the typical arrangement of giant cells, epitheloid cells and leucocytes may be found in diseases of distinctly different clinical manifestations, such as syphilis, actinomycosis and pneumonia. while on the other hand Langhan's giant cells are frequently absent in the nodules of tuberculosis, especially in the acute Recognizing its infectious nature, modern pathologists define tuberculosis as a specific disease, due to the proliferation of the bacilli tuberculosis, associated with conglomerates of cells, mono- or multi-nucleated, which cells show a disposition to undergo caseous degeneration. Thus the demonstration of the bacilli tuberculosis in the tissues becomes a positive diagnostic evidence, and when, as in the pulmonary form, this can usually be accomplished with a few simple staining processes and a microscope, the diagnosis of the disease is, as a rule, readily determined. But, while pulmonary phthisis is the most frequently occurring form in adults, in children we meet with tuberculosis in a diversity of localities. which not only produces confusing variations of symptoms, but, at times, as in cerebral meningitis, renders microscopic analysis wholly inoperative. Hence, the most careful consideration based on symptomatology alone may sometimes fail to yield a positive diagnosis, but the difficulties which here confront us, should, rather than discourage, stimulate to a closer observation and study of all signs available, not only in a direct method of diagnosis, but in that by exclusion as well. As a final criterion in the affection of the glands, bones and skin, where microscopical examinations seldom are decisive, animal inoculations may be resorted to, but these require from four to ten weeks for development.

Desiring to avoid a tedious text-book essay, I shall endeavor, at the risk of adding nothing new to your fund of knowledge, to present a few salient points, which, if stored in memory's accessible recesses, may by differentation afford a clue to correct diagnosis.

Scrofula and tuberculosis have long been regarded as inti-

mately related diseases, but the former is now only used as a clinical term. The excessive growth of all lymphatic tissues predisposes childhood when tainted with vicious hereditary influences affecting chiefly the lymphatic system, as syphilis and tuberculosis, or when exposed to unfavorable physical surroundings, to inflammatory disorders of lymphatic glands and mucous membranes; and to this predisposition the term scrofula has more recently been restricted. Modern pathology refuses to recognize any peculiar histological structure as distinctly strumous, since it differs in no respect from that common to chronic tuberculosis. Moreover, since almost all socalled scrofulous glands are now believed to be secondary to some abrasion or inflammation of the skin or mucous membranes, and, showing a great tendency to caseate—the caseous material uniformly producing tubercular inflammations, with the bacilli, in animals experimentally inoculated-scrofula connot, in the present light of pathology, be regarded as an independent disease.

The diagnosis of tubercular glands is done largely by exclusion. The enlargement shows a slow progressive course, with none or mild symptoms of inflammation. Of all lymphatic glands the submaxillary show the greatest tendency to involvement.

Glands showing much tenderness, redness and heat point to some eruption or abrasion within their areas of absorption.

In syphilis the enlarged glands are usually found in large numbers, and have a smoother and more even surface than in tuberculosis.

Lukemia has also a number of moderately enlarged smooth glands. The proportion between anemia and emaciation is greater than in tuberculosis, epitaxis is frequent, and the spleen is usually enlarged. Microscopical examinations of the blood shows an increase in the mono-nucleated white corpuscles, with a reduction in the number of the red cells.

In Hodgkin's disease the glands are at first movable and not tender to touch, but later become confluent masses. The glands may vary in size from month to month. There is an intense anemia from destruction of red cells, palpitation, dropsy and hemorrhages not to be accounted for by a local tubercular lesion. The glands most frequently affected are the anterior cervical, but any lymphatic tissue may be primarily involved.

Pulmonary tuberculosis in children is much more difficult of recognition than in the adult because of the less favorable conditions for physical diagnosis, the less liability to involvement of the apices of the lungs, and the normally less stable relation between pulse, temperature and respiration. The family history, the previous health of the patient, the duration and general aspect of the disease must chiefly be considered in differentiating between tuberculosis, bronchitis and pneumonia. A protracted course, with evening rise of temperature, a progressive emaciation, anemia and cachexia, when associated with patches of increased resonance of the lungs, especially of the upper lobes, should lead us to suspect tubercular infection. Crepitant rales are not often elicited in young children, as they are usually marked by coarser rales.

Cough, with mucous rales, absence of consolidation, mild constitutional symptoms varying in intensity with the local obstruction, are pathognomonic of chronic bronchitis.

Chronic broncho-pneumonia resembles pulmonary tuberculosis in presenting small areas of consolidation, but while in the former the posterior borders and lower lobes of both lungs are usually affected, in the latter, the consolidations frequently involve the upper lobes.

Lobar pneumonia may, from the lack of palpable chest symptoms in the beginning of the attack, the fever, the delirium and coma suggest tubercular meningitis. It differs, however, in the rapid onset, the violence of the fever and the gradually developing physical signs of lobar hepatization.

A lingering malarial fever, of a remittent or intermittent type, with bronchitis, emaciation and anemia, sometimes simulates miliary tuberculosis so closely that a diagnosis can only be inferred from the temperature curve—the exascerbations of material fever usually occurring during the day, while the highest daily temperature of tuberculosis almost always in the evening. In this, as well as in the preceding disorders, the diagnosis may still remain in doubt, but if the cough is loose, and sputum can be obtained either by expectoration or, in

young children, by irritating the pharynx during a coughing spell, the microscope can usually settle the difficulty.

In tubercular meningitis we must, for obvious reasons, in most cases depend upon general symptomatology for its diagnosis. The indications are: Family history, a gradual onset manifested by irascibility and moroseness of temperament, headache, a tottering gait, a subnormal or only slightly elevated temperature until paralysis sets in, a retarded and irregular pulse, irregular respiration, sudden propulsive attacks of vomiting, constipation, retracted abdomen, diminished urinary secretion, stupor, coma, convulsions and paralysis.

Simple meningitis and rheumatic meningitis have a more sudden attack and a higher fever than the tubercular form.

Cerebro-spinal meningitis differs in its shorter prodromal stage, a higher temperature, comparatively less stupor, hemorrhages and exanthem.

Typhoid fever has frequently been mistaken for tubercular meningitis. The points of difference are: Onset more rapid, the cerebral symptoms are attended with more fever, the bowels are usually loose and the abdomen distended.

Hydrocephaloid may present many symptoms of meningitis. It is usually preceded by gastro-enteritis; the fontanel when open—tense and bulging in meningitis—is depressed; and a temporary improvement can usually be observed in the patient's condition after the administeration of a stimulant.

Uremic coma may be recognized by analysis of urine. The paralysis of tubercular meningitis is usually local; of uremia, general. Pupils are immovable in meningitis, but, if dilated, respond partially to light in uremic coma.

Intestinal tuberculosis is apt, especially when it is the primary lesion, to be confounded with entero-colitis. The tubercular affection ordinarily presents a progressive anemia and wasting notwithstanding an improvement in the stools, more marked cerebral disturbance, a higher temperature, frequently enlargement of the spleen and lymphatic glands, ocalized paralyses, and usually cough and patches of consolidation of the lungs. Careful microscopical examination will frequently detect bacilli tuberculosis in the stools.

In chronic entero-colitis, on the other hand, we find the

constitutional symptoms in proportion to the intestinal lesion as manifested by the stools, fever only when arising from complications, depression of fontanel, less mental symptoms, no paralysis, and rarely enlargement of the spleen.

Tuberculosis of the bones or joints is often due to an infection from a primary focus. Since all chronic suppurative processes of the bones in children—so-called scrofulous inflammations—have been shown to contain the bacilli tuberculosis, the diagnostic symptoms are identical with those of chronic abscess.

On the skin, tubercular inflammation results in the formation of tubercles and papules, which by discharging upon the surface form soft, granulating ulcers leaving cicatrices on healing or showing no tendency to heal.

Lupus, the most frequently occurring form in childhood, is characterized by its slow, tedious course, the formation of soft yellowish-brown nodules, which slowly become converted into ulcers, finally cicatrizing more or less completely.

Syphilitic ulcerations differ by their more rapid course, the harder and more sharply cut edges, a greater tendency to extend to, and involve, the deeper structures, and by their simultaneous appearance on various parts of the body.

Eczema is differentiated by its greater hardness, absence of ulceration and cicatrization, and spreading by direct continuity of surface.

Finally, it must be remembered that tubercular processes are apt to become engrafted by infection upon any part or organ whose vital resistance is weakened by disease or unfavorable surroundings, and thus insiduously develop under the mask of a less formidable malady.



Book Reviews.

Conservative Gynecology and Electro-Therapeutics. A Practical Treatise on the Diseases of Women and Their Treatment by Electricity. Third Edition, revised, rewritten, and greatly enlarged. By G. Betton Massey, M.D., Physician to the Gynecic Department of Howard Hospital, Philadelphia; Late Electro-Therapeutist to the Infirmary for Nervous Diseases, Philadelphia. Illustrated with 12 full-page original chromo-lithographic plates in 12 colors, numerous full-page original half-tone plates of photographs taken from nature, and many other engravings in the text. Royal octavo. 400 pp. Extra cloth, beveled edges, \$3.50 net. The F. A. Davis Co., Publishers, 1914-16 Cherry street, Philadelphia.

This, although a new edition of the author's work, Electricity in the Diseases of Women, has been so thoroughly rewritten and extended to include the latest advances in this subject as to become a new book, and a very thorough exposition of the application of electricity in gynecology. The title conservative justly applies to the work, as the author is not carried away with the fad of regarding gynecological treatment as essentially surgical. Nearly all the modern treatise on gynecology have been written, the author says, from a purely surgical standpoint, leading often to a perspective view of these affections that unduly exaggerated the mechanical side of pelvic pathology. Opportunity is thus afforded for the rescue from oblivion of certain neglected facts as to the origin and nature of inflammatory diseases of the uterus and adnexia, and for the fuller consideration of the neural disorders most frequently found among women, while special attention is accorded to fibroid tumors and their treatment by Apostoli method and the author's method for the treatment of cancer. The book is a thoroughly practical one, clearly written, the methods of applying the current, of diagnosis, of examination, and of the various currents and their therapeutic value being clearly set forth. The illustrations are excellent, being in the

case of the colored plates from life and fully illustrates the subject. It is a work of exceptional value for the general practitioner.

Diseases of the Skin. Their Constitutional Nature and Cure. By J. Compton Burnett, M.D. Third edition, revised and enlarged. 264 pp. Cloth, \$1. Philadelphia: Boericke & Tafel; 1898.

This, the third, edition of Dr. Burnett's interesting and instructive monograph upon diseases of the skin, has been considerably enlarged by the addition of Part III., treating of the "cure of alopecia areata by constitutional remedies without any local application whatever." This is, in fact, the keynote of the book—the cure of skin diseases by constitutional treatment. As the author graphically says of the skin: "That being biologically within the organism, being fed from within, having its life from within, having its health from within and having its disease from within, it must be also treated medicinally from within, a statement with which all homeopathists will agree. The book is written in Dr. Burnett's inimitable style, with numerous illustrative cases which exemplify not only the author's theory of the cause of the diseased condition but his method of treatment as well. It is a book which can be read and reread with profit.



Cypripedium in Wakefulness of Children.

Children awaken from their naps before they should, awaken completely, wide awake, without apparent cause.

Sepia in Constipation.

For constipation after childbirth sepia is the remedy.

Ferrum phos. in Summer Diarrhea of Children.

In the summer diarrheas of children one finds it indicated where the patient vomits continuously, with waterv and bloody stools, and the child decidedly emaciates within twenty-four hours. He then lies in stupor, with a red face, half-opened eyes and dilated pupils; the pulse is full and easily compressible, and it throws its head continually from one side to the other, with sudden starting during sleep.

Calc. carb. in Leucorrhea.

Calcarea carb, contains in its pathogenesis a milky discharge producing heat and itching of the vulva. Menses early and profuse, with aggravation of leucorrhea before the period. Mentally ill-humored; cries easily and fears she will lose her reason. The sixth trituration three times daily.

Plumbum in Dysmenorrhea.

The menstruation stops at the beginning of the colic.

Silicea in Rachitis.

Open fontanelles; head too large and rest of body emaciated; pale face; abdomen swollen and hot; ankles weak; profuse head-sweat and body dry; likes wrapping up warmly; offensive diarrhea; stools contain undigested food; swelling and suppuration of glands and bones; ulceration and necrosis; cellular inflammation.

Borax in Infantile Diarrhea.

Easily started, apthæ upon the tongue or inside the mouth. Child pale and hot; undigested and offensive stools. Dr. Bell makes a suggestion which we think should be remembered, that belladonna is frequently given where borax should have been.

Calcarea phos. in Backache.

Backaches and headaches of school girls, especially during the catamenia. With this remedy there is mental anxiety with all the troubles. Has cured a number of cases of backache in young school girls who were disappointed in their little love affairs, all their mental disappointment seeming to go to their backs.

Lachesis in Ovarian Pain.

Pain in left ovary, darting upward; pain and sensitiveness to weight of clothes, pain extends from right to left, boring or burning pains relieved by discharge of blood from the vagina. Intolerance of slightest touch. Physical and mental weakness. Leucorrhea, acrid, slimy green or thick yellow. Lach. is es-

pecially useful during climacteric period and for affections of weak, melancholy women or for young girls who are chlorotic with sickly complexions.

Lillium tig. in Leucorrhea.

Thin, acrid, excoriating, leaving a brown stain, with intermittent labor-like pains in sacral region, worse afternoon and evening.

Merc. in Mammary Abscess.

Especially if transient chills or throbbing indicate the probable formation of matter; also in cases where suppuration takes place in different parts of the breast.

Ignatia in Chorea.

When the disease is developed as a result of moral causes, spasms are worse after eating.

Ergot in Uterine Hemorrhage.

Hemorrhage after accouchement or abortion, rarely useful in metrorrhagia or menorrhagia—it should be employed in physiological because the hemorrhage is produced in these cases because the arteries remain open—the ergot closes them. It is sometimes useful in metrorrhagia of the menopause; flow black and of bad odor; aggravation by the least movement; skin cold; menace of collapse.

Rhus tox. in Scarlatina.

The rash is rough, sometimes dark colored and itches violently. There is drowsiness with muttering delirium. Tongue at first coated white with triangular red tip, then red and smooth; in worse cases dry, red and cracked. Pain in limbs and joints, causing patient to constantly change position. Ichorus yellow, thick discharge from nose.

Coccus cacti in Whooping Cough.

This remedy has paroxysms of cough with vomiting of clear, ropy mucus, extending in thick, long strings to the floor. This is sometimes seen in children who cough and cough with this tenacious mucus stringing from mouth and nose, waving to and fro until it finally gives way. The paroxysms come on in the morning, and accompanying them there is often vomiting of a clear, ropy mucus. Eructations of wind following cough are an indication for Ambra grisea. Coccus

is a useful remedy for the protracted bronchial catarrhs remaining after whooping cough. The excessive secretion of mucus under coccus is marked, and causes the child to strangle.

Podophyllum in Infantile Diarrhea.

Green, sour, watery stool, or yellow mixed with mucus and very offensive—preceded by griping colic. Stools of podo. and puls. are both changeable. May be undigested or clay colored—prolapsus ani. Great exhaustion.

Helonias in Uterine Disease.

Atonic condition of female organs, prolapsus with general malnutrition and mental depression; sensation of soreness and sensitiveness of the uterus; the patient "is conscious that she has a womb." Offensive leucorrhea with erosion of the cervix, which occasionally causes hemorrhage. With local uterine symptoms of displacement or of chronic inflammation, etc., there is generally pain in the lumbar region, dull aching, sometimes weight on the chest, pressure on the head. Pruritus of vulva and vagina, which are hot and swollen and exfoliate; aphthous patches. Induration of uterus.

Graphites in Dysmenorrhea.

Intolerable itching before menstruation and a gushing leucorrhea day or night.

Graphites in Climacteric.

What pulsatilla is to puberty, graphites is to the climacteric.

Murex in Leucorrhea.

The cervix is sore and ulcerated and there is a discharge of greenish blood-streaked leucorrhea.

Lachesis in Neurasthenia at the Menopause.

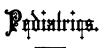
Lachesis in its proving has a poisonous action simulating the venom of the viper; as a clinical remedy, its symptoms are those of the adynamic forms of disease; pathologically, it develops asthenic inflammations, malignant degenerations, and a general tissue depreciation which is slow in development and still slower in the tendency to recovery. Primarily we observe its action upon the pneumogastric, and, secondarily, in the blood inoculation which permits fibrine decomposition. Through the pneumogastric it permits a loss of vasomotor in-

hibition, and hence the undue afflux of blood at different centers. Thus we see the heart depression, and the gastric and alimentary functional crisis and the uterine disorders, particularly at the time of the menopause. As it shuts off the vagus inhibition it permits successive dilation of the vaso-dilators, until by exhaustion they cannot act in consonance with the vaso-constrictors. Then occur the pronounced changes in the active functions, like menstruation.

Physiologically "the change of life" simulates the vital depression observed in the proving of lachesis. The nervous energy necessary for regular menstruation naturally becomes exhausted as a woman approaches the middle of her life; the cerebro-spinal system loses its elasticity, and pneumogastric inhibition is weakened. It is then that we notice the peculiar nervous phenomena which are incident to the time when all the energies are waning, and the system is trying to adjust itself to a new order of existence. Therefore lachesis, with its similar symptoms, is often indicated at the climacteric.

Trillium at the Menopause.

Trillium has a most profuse hemorrhage at the climacteric period. The flow may be bright red or dark or clotted and induced by the slightest over-exertion. Syncope, vertigo, dimness of vision, palpitation, severe pain in the back, and persistant recurrence of the flow every fourteen days. The face of the trillium patient is generally sallow, and she may even present the yellow saddle across the nose, so characteristic of sepia.



The Contagion of Whooping Cough.

Dr. Weill (Lyon Med.) on various occasions permitted nearly one hundred young children, who had not previously suffered from whooping cough, to be associated in the same ward for twenty days or more with children suffering from the disease during the stage of whooping. In only one case

was the disease contracted, and in this instance the patient from whom the infection was derived was in the very earliest period of the whooping stage. In three small epidemics Weill was able to satisfy himself that infection was contracted from children who had not yet begun to whoop. He concludes that infection ceases very soon after the characteristic whoops commence, and that therefore in a family it is not the patient who is already whooping, but his brothers and sisters who have not previously had whooping cough, that ought to be isolated.

Cynecological Plassings.

Spincteric Hysterotomy.

Dr. Defontaine (Archiv. Prov. de Chir.) describes an operation for free division of the uterine cervix intended not merely as a preliminary measure in removal of an intrauterine tumor, or to facilitate exploration of the uterine cavity, but for the purpose of abolishing the functions of the sphincter, and, consequently, of modifying the physiological and patholical conditions of the uterus. Division of the sphincter, it is held, is mere effectual than amputation of the cervix in causing involution of the uterus, and, consequently, of ameliorating certain forms of metritis and of uterine deviation. Sphincteric hysterotomy, the author states, is indicated in cases in which it is necessary (a) to assure evacuation of the contents of the uterine cavity; (b) to facilitate involution of the uterus: and (c) to prevent the upward extension of any infective process toward the oviducts. It is regarded as a measure of radical treatment in cases of metritis and of affections of the uterus complicated by septic inflammation, particularly uterine flexions and dysmenorrhea of uterine origin, and also, advanced retraction of the cervix. It acts by allowing complete evacuation of the uterine cavity, and by facilitating involution of the diseased organ. The operation is rendered a harmless one, if performed under proper antiseptic methods and Hydrozone is the agent recommended, and has had good results after the failure of dilatation of the sphincter and curetting. It should be practiced only in cases in which the expectation of conception no longer exists, or when the gravity of the affection leads to a disregard of inconvenient consequences in this respect. It is stated, however, that an autoplastic operation may in certain cases re-establish the uterine sphincter, and favor the possibility of pregnancy

Hydatiform Mole.

Dr. Murry makes the following deductions:

1. That women near the menopause who are irregular in menses should always be examined to determine the cause.

2. That the possibility of hydatiform mole being a cause of metrorrhagia and serious discharge should always be borne in mind.

3. That fibroids of the uterus may be present, yet the cause of flowing may be hydatiform mole.

4. That hydat form mole may be present without obvious

signs of pregnancy.

5. That the proper treatment of the condition is dilation of the uterus, removing the mass and packing the uterus, to be followed by ergot to keep the uterus contracted, all operations to be done aseptically, and with all means of controlling hemorrhage at hand.

6. That after the uterus is emptied the danger is not over, as the villi, which is cystic, may have perforated the uterus is first washed out by prolonged irrigation with a the peritoneum.

Adenoma and Polypii of the Uterus.

These common diseases are now looked upon with more suspicion than formerly, particularly when they appear after the climacteric and recur after extirpation. Clinical experience has shown them to be often only preliminary to cancer, and a radical operation is necessary to avoid the danger. In younger women the former methods of treatment are employed, but the cases are watched carefully for any signs of trouble.

Management of Solid Tumors of Ovaries during Pregnancy.

Dr. Swan (Johns Hopkins Hosp. Bull.) arrives at the following deductions:

1. Solid neoplasms of the ovary, complicating pregnancy,

are exceedingly rare.

2. The diagnosis of this rare combination of a physiological and pathological process may be very difficult. The physical examination with the signs of pregnancy, and those which belong more particularly to solid ovarian growths, will generally enable us to make at least a probable diagnosis and one sufficient to warrant an explanatory section.

3. The prognosis in cases of solid growths of the ovary

complicating pregnancy is much worse, both for the mother and child, than in those of cystic neoplasms of these organs. This is to be explained by the fact that the former are usually smaller, and remain in the true pelvis and obstruct the parturient canal; while the latter, owing to their bulk and consistence, rise above the pelvis, and the dystocia, if produced at all, is of a less serious nature. Abdominal section and extirpation of solid tumors during the early months of pregnancy produce equally good results, so far as the life of the fœtus is concerned, as in the case of cysts; the ultimate result in the case of the mother depending, of course, on the malignant or benign nature of the growth.

- 4. The general rule should be to operate on all cases between the second and fourth months of gravidity. It would be hard to find a stronger argument in favor of the elective operation for extirpation of these ovarian neoplasms than is furnished by a comparison of the statistics of the best author-
- ities.
- 5. The compulsory operation during the latter half of gestation, during labor, or the puerperium will rarely be required.

Puerperal Tetanus.

In the literature of puerperal tetanus the presence of Nicolaier's bacillus has been reported but three times, by Chantemesse, by Heise, and by Stern. Dr. Rubeska has observed six cases of this disease. In all of the cases there was operative interference with the labor, and infection probably resulted through wounds made at the time of the operation. Chill, fever, and fetid lochia have all been present. The symptoms usually came on in from six to nineteen days after the delivery, and the results were uniformly fatal in from two to three days.

The author has collected together all of the reported cases, twenty-one in number, and shows that in one case only did

recovery take place.

Calcareous Degeneration in the Uterus.

Dr. Cohen (Med. World) reports a rare case of the foregoing, the patient being fifty-seven years of age and the mother of eleven children. For nine years past she has been flooding at least twenty days in each month, with constant pain in the lower abdomen, which has been intense for the past two years. When seen by the writer some months ago she could not lie in a recumbent position and breathing was difficult, vomiting being also very frequent. Upon examination a large mass was detected in the pelvis, intimately associated with the

uterus; it was impossible also to pass a sound in the uterus. The latter organ was much enlarged but freely movable. Both ovaries were enlarged, the left more so. A complete hysterectomy was subsequently performed, the patient living but twenty-four hours thereafter. Examination of the specimen removed showed that the uterus had undergone a calcareous degeneration; a large calculus was found in the body of the uterus, accompanied by a number of smaller ones, many being like grains of sand; the interior of the uterus felt sandy, the latter being so numerous. Several cysts were connected with each other, being part of the uterus, each cyst containing from one to ten calculi. A calculus about two inches in length was also found in the left ovary. A fibromyoma about four inches long, not cystic, was also a part of the uterus.

Uretero-Vaginal and Uretero-Abdominal Fistulas.

Dr. Ferguson (Amer. Jour. of Med. Science) collected sixty-five cases of the above disease, and observed two himself, making sixty-seven cases in all. Of this number sixty were uretero-vaginal, four uretero-uretine, and three uretero-abdominal. This does not include fistulæ from the kidneys, nor the uretero-lumbar and uretero-inguinal varieties. No cognizance was taken by the author of the various primary operations performed on patients' accidentally injured ureters while operating upon the pelvic organs. The ages of the patients varied from nineteen to sixty-four years, excluding those persons having the congenital forms.

After dwelling upon the etiology, some of the operations,

and results, the author concludes:

1. The left ureter is more frequently the seat of trouble than the right.

2. The most frequent variety is the uretero-vaginal, and the rarest is the uretero-abdominal.

3. The most common cause is difficult labor, and forcepsdelivery is a prominent etiologic factor.

4. Of all the operations performed in the pelvis, vaginal hysterectomy is the most frequent cause of ureteral fistula.

5. Other conditions being favorable, all cases of ureteral fistula are curable by operation: (a) In all cases of ureterovaginal fistulæ the direct method of operating should be selected, and no particular operator's method is applicable to all cases. When the ureteral opening is situated close to the bladder, Schede's operation is the most surgical, and is applicable to the greater number of cases; when situated far away from the bladder, a plastic operation may be tried before a graver and more mutilating procedure is thought of. Intraperitoneal operations are suitable for abdominal fistulæ.

For the cure of uretero-vaginal fistula, hysterectomy, nephrectomy, and colpocleisis are, in the author's opinion, entirely unjustifiable procedures. When septic infection of the kidney occurs it may be necessary to open or remove it. It bespeaks lack of surgical ability to remove a kidney, a uterus, or close a vagina in these cases of simple fistulæ.

Another procedure which the writer thinks uncalled for is transplanting of the cervix uteri into the bladder for the treatment of uretero-uterine fistula, for it causes sterility, and the menstrual flow is abnormally directed; and, besides, a disturbed bladder might cause a backward flow of urine into the uterus, Fallopian tubes, or even peritoneal cavity, depending upon the condition of the organs.

Directing the urine into the bowel is only justified when any other operation cannot be performed. While ureteroenterostomy has been successfully performed, it has but little

to recommend it on general principles.

Peritoneal Adhesions.

Nove-Josseraud and Goinard (Lyons Med.) relates three cases in young women on whom operations on the internal genitals were succeeded by pain which continued until a second abdominal operation was performed, and division of the peritoneal adhesions was followed by the relief of pain. The authors give a general account of peritoneal adhesions that cause pain, usually due to inflammation of one of the abdominal viscera. They may be set up by laparotomy, but it does not appear probable that contusion of the abdomen. apart from the inflammation, has, as Reidel has suggested, set up intraperitoneal adhesions. In addition to giving rise to acute and chronic intestinal obstruction, adhesions may cause much pain. The character of the pain is variable; it may be fixed in position and continuous, and not preserve any relation to intestinal movements, or it may be intermittent, resembling colic and preceding defecation, after which physiological act it is relieved for a time. Adhesions may also become more painful during menstruation. By interference with the intestines they may produce constipation, and when attached to the bladder they may give rise to cystitis and dysuria. With regard to operative interference, the diagnosis being difficult, the adhesions are sometimes only discovered on opening the abdomen. Against the objection that operation itself is likely to give rise to fresh adhesions, it is suggested that after operation the intestines should be kept in active peristalsis by purgatives and enemata. In pelvic adhesions the Trendelenburg position will be found useful.

Dustehrics.

Cause of Extrauterine Pregnancy.

Dr. Strassman (Berlin, klin, Wochenschrift): This condition occurs when the impregnated ovum is retarded in its passage through the tube to the uterus. The ovum settles in some portion of the Fallopian tube, where it becomes surrounded by the chorionic villi. Among some of the factors bringing about this condition, may be mentioned: A previous catarrhal inflammation of the epithelium, with destruction of the latter; formation of strictures; infiltration of the walls; the pocketing and isolation of a portion of the tube; this latter condition, with a diminution of the lumen, is one of the most common conditions found. Peremetritis is also instrumental in its causation. Developmental errors in the tube's formation act as a predisposing cause; as hernia, diverticula, accessory ostia or tubes. Finally extrauterine pregnancy may occur if the product of conception is too large for the canal or if there occurs a change in its consistency. Slowed propulsion, abnormal length of the tube, the wandering of the germ from the other ovary, or primary abnormality of the ovum, and the blocking up of the channel by a profuse hemorrhage from rupture of a follicle, all may act as predisposing factors.

Pain and Menstrual History of Extrauterine Pregnancy.

Dr. Cooke Hirst (Jour. of Obst.): There are three cardinal symptoms of ectopic gestation: Pain, characteristic in nature. manner of occurrence, and situation; irregularity of menstruation, often with the discharge of what the patient calls "pieces of flesh" (decidua); and these physical signs: for the first two, three or four weeks a small swelling in the tube, no bigger than the end joint of one's thumb, and unadherent; later an exquisitely sensitive mass fixed in the pelvis by thick, velvety adhesions. He presents tabulated histories of his cases for the purpose of disproving the statement in a recent English monograph, which has been copied in a text-book, that pain is not a symptom of this condition. He states the pain is described by the patient in strongest terms; occurring in paroxysms with intervals free from suffering; appearing at any time from a few days or months after a normal menstruation; situated often in one groin, though frequently indefinitely referred to the lower abdomen; extending down one leg or up to the epigastrium; and pain so severe as to occasion profound systemic disturbance—syncope followed by nausea and vomiting, a cold sweat, hysterical outbreaks, complete disability, and every appearance of excessive shock, and these symptoms do not necessarily indicate rupture of the sac and internal bleeding.

In regard to the menstrual history one is struck with the fact (in his cases) that it is irregular and often there has been no cessation at all. Prolonged uterine bleeding, preceded or followed by the discharge of decidua, is the almost universal rule at some period in the history of a tubal pregnancy.

Eclampsism, or Puerperal Eclampsia without Convulsions.

At a recent meeting of the Obstetrical Society of France there was an interesting discussion on a condition that M. Bar proposes to call "eclampsisme." In eclampsia, says Bar, the occurrence of convulsions is a capital feature, and it aggravates the prognosis very decidedly, but what needs to be known is the fact that there are a good many cases in which no convulsions take place, but instead the patient is attacked by very intense neuraligia, mania, diarrhea, or some other striking symptom. Such cases may prove fatal, and that speedily. Bar seems to have been the first to take cognizance of this condition, but his remarks on the occasion in question were called forth by the histories of two cases reported at the meeting by Budin.

Budin's first case was that of a primipara, aged thirty-one years, who had arrived at term and was brought to the Maternity Dec. 16, 1897. She had prodromes of eclampsia, and there was a notable amount of albumen in her urine. She also had gastralgia, headache, disturbance of vision, and a cerebral condition which Budin simply called "singular," without describing it. She was delivered spontaneously of a living child, and the delivery was followed by hemorrhage which, although the amount of blood lost did not exceed twenty-five ounces, called for artificial removal of the placenta. After this the prodromes of eclampsia became more pronounced, her general condition grew worse, and in spite of every care, she died in seven hours, without having had a convulsion. the post-mortem examination the charactertistic renal lesions were found, and the liver presented ecchymotic spots having the geographical contours seen in cases of eclampsia.

The second patient was also primipara, who continually had "oppression." At the time of her entering the Clinique Tarnier, March 15th, she had albumen in the urine, visual disturbances, etc. She was considered to be in imminent danger of eclampsia, and was treated accordingly. She was delivered a week later without having had a convulsion, although at

every instance one was expected to occur. The placenta showed patches of atrophy and numerous hemorrhages, some old and others recent. This woman recovered.

It is of very great importance, says Budin, to observe the premonitory symptoms of eclampsia. Patients may have self-intoxication, he continues, and be found in a real state of cclampsia, without having any convulsive attack. Formerly, he adds, convulsive seizures were looked upon as the characteristic mark of eclampsia; they are still the cardinal feature in the majority of cases, but they are only one among numerous symptoms of self-intoxication; they are the most striking, but the others should not be overlooked, either from the diagnostic or from the therapeutical point of view.

An interesting contribution to the casuistics of the condition was made by Demelin, who related the case of a woman who had all the premonitory symptoms of eclampsia, but no convulsions. Jaundice soon supervened, however, with hematuria and hemorrhage from the nose and the gums, so that the diagnosis of icterus gravis was made. The jaundice and the hemorrhages ceased at the same time, and the patient recovered.

We can hardly doubt that Bar has drawn attention to a phase of the perils of childbirth which, if it has not been altogether overlooked heretofore, has at least not been generally appreciated. By so doing, he has certainly performed a service far greater than that resulting from the most of the new operations that are invented in such profusion.—N. Y. Medical Journal.

Primary Treatment of Post-Partum Hemorrhage.

Dr. Curran (Med. Record): After carefully discussing the various methods employed and suggested by authorities for the primary arrest of post-partum hemorrhage, the author advocates the compression of the abdominal aorta with the ulnar surface of the closed left hand, compressing the aorta against the spine. He maintains that the pressure should be continued until all bleeding has ceased, thus allowing time for clots to form in the mouths of the uterine sinuses and for muscular contractility to have returned. Not until this has been accomplished are the secondary measures, such as ergot, douche or tamponade, indicated.

Periodic Menstrual Psychoses.

Dr. Trenel relates a case of delirum with hallucinations occurring at the menstrual periods in a woman thirty-seven years of age who had given birth to a child some years previously. The attacks took place in January, March, April and May, 1896, and on the two last occasions were followed by melancholic depression lasting for a few days. Such cases are rare, but may be met with in either early, late or middle menstrual life; and may be acute, subacute or chronic. The intervals between the menstrual periods are generally free from mental symptoms. The prognosis is relatively favorable, 68 per cent ending in cure, but the condition may become chronic, or may be followed by dementia, or may be transformed into ordinary insanity. When there are co-existing lesions of the genital organs, removal of the ovaries may be indicated, and may sometimes give good results, but recourse to operation should be had only after a long period of observation. Treatment in the attacks should usually be carried out at home, and not in an asylum.

Cysticercus Cellulose in the Milk.

Dr. Gundellach reports, in the Zeitsch. f. Fleisch- u. Milchhygiene, Vol. VII, p. 119, the finding of seven cysticercæ in the milk of a hog. This is the only case thus far reported of the finding of the parasite in the milk.

NOTES.

THE SWEETWATER HOTEL.

Physicians returning from the east are loud in their praise of a new summer resort which has just opened to the public in Massachusetts, on the property of Dr. W. R. Hayden, at Bedford Springs, who is so well known to the profession of the country through his viburnum compound. This new hotel is situated in a region surrounded by so many places of historical interest as to make it well worth one's time to visit it, and the accommodations are of the highest order.

CHAMPAGNE FOR THE WOUNDED AND SICK.

Surgeon General George W. Sternberg was tendered, and has accepted, the generous donation, by Messrs. G. H. Mumm & Co., France, through their agents, of 1,200 bottles of their famous extra dry champagne. The Treasury Department has allowed this wine to be delivered from bond, free of duty, and part of it has already gone to Santiago on board the steamship Olivette for the sick and wounded, while the balance will be sent where it will do the most good. As champagne is very highly esteemed in the treatment of yellow fever, and will greatly add to the comfort and health of the sick, as well as the wounded, this munificent gift will be greatly appreciated by the sufferers, especially as such delicacies cannot by any possibility be afforded by the army and navy commissary, and it is hoped this donation will stimulate other firms to similar contributions.

THE HOMEOPATHIC

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EDITOR, B. F. UNDERWOOD, M. D., 133 William Street, New York.

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ACUTE DYSPEPTIC DIARRHEA.

BY DR. T. F. H. SPRENG, SIOUX CITY, IA.

Read before the American Institute of Homeopathy, June, 1898.

Dyspeptic diarrhea includes nearly all the cases of summer diarrhea. It at least forms a stage in these cases—nearly always the initial stage, but sometimes it is the final one.

The etiological factors entering into the causes of dyspeptic diarrhea, are summer heat, artificial feeding, bad habits of feeding, improper foods, impure milk, bad surroundings and city residence.

We have not the time here to discuss separately these different factors. We are, however, constrained to say a word on the bad habits of feeding. The pernicious practice indulged in by so many mothers, of applying the infant to the breast, at any and all times, in order to still its cries, should be dis-The mother should be impressed with the couraged. importance of regularity in feeding. Of hand-fed infants, we believe, that thousands have been sacrificed by the use of that most treacherous breeder of disease germs—the flexible nursing tube. A thing like this, which requires so much care

to make it what it seems—a simple, harmless device—ought never to have found its way to the lips of the new-born. Aside from itself being a disease breeder, its use encourages the pernicious habit of filling a large nursing-bottle and putting the nipple into the child's mouth, while it lies in its crib or carriage, allowing it to eat and sleep alternately, for the greater part of the time. By taking food in this irregular manner, there can be no such thing as healthy digestion.

The administering of food in proper quantities, at proper intervals, with absolute regularity, and the stopping of night-feeding and nursing as early as possible, is the first essential of healthy digestion.

Dyspeptic diarrhea is caused by undigested food in the intestine and by the putrefactive changes in such food. If the cause is a transient one and the resistance of the patient is great, and the case properly managed, there is only functional disorder and complete recovery is a matter of only a few days. But if the patient is susceptible and the existing cause continues to operate, or when the case is improperly managed, the process continues and anatomical changes are produced and thus the case which in the initial stage was dyspeptic diarrhea becomes one of gastro-interocolitis.

We meet with two forms of symptoms, first a mild form, with a gradual beginning, with little or no fever and usually without any gastric disturbance; secondly, a severe form, in which the attack is sudden and severe, attended by a high temperature and by vomiting.

In the milder form the first few days may develop no symptoms except the diarrheal discharges, a fretfulness and peevishness and the child may seem generally out of sorts. Because there are so few general symptoms, the cases are allowed to go on for several days, by mothers, under the general belief that "the children are only teething."

The stools are thinner than normal, are yellow or green, and there may be found in them masses of undigested fat and occasionally curds. The odor is sometimes offensive, but frequently not. After the lapse of a few days, the stools contain, in most cases, more or less mucus. Starchy foods and fruits may be found in the stools undigested. The appetite is usually impaired and after a few days may be lost entirely.

The tongue has on it a thin, white coating, and in very young subjects the mucus membrane of the mouth may be covered with thrush. In some cases the general health may not be noticeably affected for two or three weeks. In others, after a few days, the children grow pale, become emaciated, their limbs become soft and flabby and their spirits are depressed. If proper treatment is instituted and the cause removed, there will soon be manifest a favorable change in the color and character, as well as in the frequency of the stools. The appetite returns, and the strength and spirits revive, and the children recover after an illness of from four days to two weeks. Relapses are sure to occur by irregularities in diet, especially by over-feeding. Severe, acute symptoms may supervene at any time, and the case may develop into cholera infantum or entero-colitis. When these changes do take place, they are sudden, and are caused by a spell of very hot weather or some gross dietetic error.

The clinical picture is quite a different one in the cases developing suddenly, for some days there may have been symptoms of slight intestinal derangement, or the attack may begin abruptly in a child apparently healthy. The child is restless, cries much, seems in distress, and sleeps but a few minutes at a time. The skin is hot and dry, the temperature rises rapidly, the abdomen is distended and hard, the legs are usually drawn up, and all symptoms indicate that some grave disorder is pending. In some cases the nervous symptoms are so severe that convulsions ensue. In a very few hours after the onset the stomach and bowel symptoms manifest themselves. Vomiting first ensues, the substance vomited may be undigested food taken many hours before. If this food was milk, it comes up in hard curds, and is sour. As the vomiting continues, the substance thrown off consists of mucus and serum and sometimes bile. The taking of food or drink easily excites vomiting.

Diarrhea soon follows, the stools are the first feculent, but soon become very thin, yellowish in color and of a very offensive odor, and are accompanied by great bursts of flatus. In some cases the stools are green or greenish yellow, gray or brown. The characteristic features are, "the colicky pains preceding the discharges, the amount of gas expelled, and the foul odor."

In a large per cent of these cases a free evacuation of the bowels is followed by a decrease in temperature, the nervous symptoms subside, the child falls asleep, to be aroused for an occasional stool after a few hours.

While in the beginning the prostration is often great, it is of but short duration, and if properly treated, the acute symptoms will subside in from twenty-four to thirty-six hours, and the case go on to a rapid recovery.

If the child is cachectic and badly nourished the fall of the temperature is often only temporary, vomiting may have ceased, but the diarrhea continues, the stools change in character, are not so fluid and not so offensive, there is present more mucus, and they may contain some blood; in other words the case merges into enterocolitis.

Such are the symptoms in infants. In children over two years old the diarrhea is brought on by ingestion of some indigestible article of food, such as unripe fruit or beries, or milk which has been tainted from exposure. The temperature is lower, but the pain is much more acute.

We distinguish dyspeptic diarrhea from cholera infantum by its milder character, the temperature being usually lower, prostration not so great, and the nervous symptoms not so marked; but more especially do we distinguish it by the stools, which in cholera infantum are large, serous, neutral or alkaline.

It is not possible in the first day or so to differentiate between dyspeptic diarrhea and inflammatory diarrhea. The onset is often identical. If the severe symptoms and fever subside in twenty-four or thirty-six hours, we may safely conclude that we have had only a putrefactive process, with functional derangement, while inflammatory changes are evidenced by a continuance of severe symptoms, and especially of the fever beyond the second day.

Hygienic and dietetic treatment is of paramount importance in the treatment of this disease—I dare say it is of greater importance than medicinal treatment. It is well to remember that digestion is practically arrested, during the acute febrile stage, therefore to give food at this time could only do harm,

irritating the stomach, until it is vomited or passing into the intestine adds to the fermenting masses there present and aggravates the existing disorder.

In nursing infants, so long as a disposition to vomit continues, food must be proscribed. Rice-, barley- or toast-water in small quantities may be given to allay thirst. If these are refused or vomited, then everything should be withheld. After the stomach has been quiet for eight or ten hours, it is safe to allow the child to take the breast, allowing it to nurse one-quarter or one-third its accustomed meal. Three hours should be allowed to elapse before the child is again put to the breast. As the child's stomach grows more tolerant the amount nursed may be steadily increased.

To be called to treat a very young infant having dyspeptic diarrhea, that is hand-fed, and in the heat of summer, is to be brought face to face with one of the most difficult problems in the management of diarrhea!

While a child that is nursing may be returned to the breast, so soon as the vomiting is permanently controlled, it will not do to follow the same rule with respect to cow's milk. Generally this must be withheld, in all forms, until the acute symptoms are past. Our reliance here is upon egg-water, chicken, mutton or beef broths, barley- and rice-water and the dextrin foods, such as Horlick's, Leibig's or Mellen's.

When the symptoms of acute fermentation have subsided and the stools are less frequent, a little cow's milk may be added to the diet.

In older children, where the diarrhea has been caused by improper articles of food, a milk diet may be given with success, but the milk should be boiled and at first a little limewater added.

Since our treatment is to be directed against the process of fermentation or putrefaction and toward the restoration of the normal gastro-intestinal functions, which have been deranged, we deem it of first importance to thoroughly evacuate the fermenting masses from both stomach and intestines. For stomach washing a large-size flexible-rubber catheter is the best instrument to use and plain lukewarm water the best fluid. A single washing in most cases will suffice.

Irrigation of the intestine should be most thorough. The catheter, or small rectal tube, should be passed into the colon—if possible beyond the sigmoid flexure. At least eight inches of the tube should be made to pass within the bowel, then the intestine above is readily filled. A saline solution—one drachm of salt to a pint of boiled water—is what we use. One irrigation in twenty-four hours is all that is required.

Of the remedies that are most likely to be indicated in the treatment of dyspeptic diarrhea, we will mention a few, together with their indications.

Arsenicum-alb. will be found to be homeopathic to the case when there is present great irritability of the stomach, vomiting after eating or drinking. The child is extremely restless, stools dark green mucus, or brown or black and watery Discharges very offensive and excoriating.

Chamomilla is indicated when the stools are yellowish-green, or liked chopped eggs, mixed with bile, they have the odor of sulphuretted hydrogen and are excoriating; there is colic before and during stool; relief after. Children are very fretful.

We think of China-off. when there is distention of the stomach, where there is slow digestion. The food seems to lie a long time in the stomach and causes eructation, and is finally vomited, undigested. Distention after eating a little is characteristic. The stools are watery and contain undigested food; the evacuations are debilitating and may be involuntary, worse after eating fruit; stools may be yellow, brown or black, and offensive.

Colocynth should be prescribed when the stools are preceded by griping in the abdomen and are provoked by the slightest food or drink. The stools are fluid, copious or papescent, and the griping is relieved by bending double.

Podophyllum suggests itself where there is a painless morning diarrhea of watery yellow stools, these are profuse and pour out like from a hydrant, preceded by retching and vomiting; the stools are worse after eating and drinking.

Croton-tig., like podophyllum, has profuse, watery, yellowishgreen discharges, gushing out like from a hydrant, but under Croton-tig. they occur when the child eats or drinks.

Calcaria-phos. will be called for in scrofulous and rachitic

children where the stools are green, slimy and undigested. It is a noisy, offensive, watery and spluttering diarrhea with a great deal of offensive flatus.

Ipecac is indicated when there is a yellowish or white-coated tongue, when there is present almost constant nausea and vomiting. The child throws up its food and large quantities of green mucus. The stools are grass-green mucus, or white, fermented like yeast. Colic and sick stomach before and during stools, and there is an inclination to sleep after vomiting.

Veratrum-alb. is the remedy when vomiting is excited by the smallest quantity of liquids. The least motion increases the vomiting. Stools greenish watery with flakes. Before stool there is severe colic; during stool, cold sweat on forehead, and there is violent thirst for cold water.



PROLAPSUS UTERI.

BY W. E. GREEN, M. D.

Read before the American Institute of Homeopathy, June, 1898.

There are but few disorders of the female genital organs that are more worthy of attention of the gynecologist than is that of Uterine Prolapsus—a condition that is progressive in its nature and is productive of much discomfort and suffering. A treatise on any form of displacement of the uterus could hardly be made comprehensible without some reference to the various lesions that produce it; and yet, to enter into a detailed account of all the predisposing pathological factors that are causatively responsible for the morbid process would require more time in its reading than is usually allotted to a paper in this Institute. In dealing with the subject of prolapsus from a practical point, the various stages of displacement must be considered. This varies, including every degree, from slight falling to the complete extrusion of the uterus through the pudendal orifice. However, for convenience in description authorities have divided uterine prolapsus into three stages:-

First. Where there is but slight sagging of the organ, without material change in its axial relations, the cervix resting on the floor of the pelvis.

Second. Where the axis is changed, the body retroverted and the cervix appears at the vaginal outlet.

Third. Where the organ projects through the vulva.

An hereditary weakness of the uterine ligaments and a faulty development of the pelvic floor are the most noteworthy etiological elements in the development of uterine prolapsus, and the injuries that these structures sustain during parturition rank among the greatest of predisposing causes. While it is true that the lacerations and overdistension of the vagina and perineum, incident to labor, enfeebling their supporting power, are cardinal factors in the production of the disease, many other causes aid in developing the morbid process, as augmented intra-abdominal pressure and increasing weight of the uterus. Prominent among the intra-abdominal causes may be mentioned weakness and relaxation of the abdominal

walls, absorption of the pelvic cellular tissue from any cause and stretching or elongation of the ligaments. All the various pathological conditions that increase the weight of the uterus aid in its descent, as sub-involution and tumors. In some subjects, where this hereditary weakness of the uterine ligaments and perineum exists to a marked degree, a complete prolapsus occurs in the nullipara where an injury of the structure has never been sustained.

The disease is progressive, and usually chronic in its advancement, the various pathological conditions that accompany it occurring sequentially. The equilibrium of the pelvic viscera having been destroyed, the organ slowly descends, taking on new complications as it advances. The cramping of the vessels causes stagnation of the circulation, with consequent hypertrophies. The uterine ligaments become stretched, and as the descent progresses the vaginal walls through their cervical attachment are dragged downward, producing both cystocele and rectocele. This process may continue until inversion of the vagina takes place and the cervix rests well outside of the pudendal orifice. The traction exerted upon the cervix often superinduces pronounced elongation and attenuation of its supra-vaginal portion; while the circulatory changes may cause hypertrophy of the infravaginal cervix and thickening and induration of the vaginal mucous membrane. The irritating qualities of the urine and the chafing of the clothing often produce abrasions and ulcerations of the protruding mass. In some instances, in which the perineal support has been destroyed and the uterine ligaments retain a firm degree of tonicity, sustaining the body in position, the cervix becomes greatly elongated, and may protrude through the introitus, presenting all the gross appearance of a genuine prolapsus of the second or third degree. In rare cases the vaginal prolapsus is superinduced by a primary hypertrophic enlargement of the cervix, which drags upon the vagina, causing an inversion of its upper segment.

The symptoms of prolapsus of the uterus vary greatly in kind and severity. Some patients suffer but slight inconvenience, though the organ may protrude from the vulva, while others, with even a slight degree of prolapsus, may

experience the greatest discomfort. In fact, incomplete prolapsus usually causes more suffering than the more advanced stages. Back-ache and dragging pains in the loins, a fee!inr of heaviness in the perineum and general fatigue are the most pronounced symptoms. Troubles in micturition are frequently encountered, as incontinence or retention of urine, dysuria or polyuria.

Diagnosis is made by an examination. In slight cases the uterus will be found to be low down, with the cervix resting upon the pelvic floor. In more advanced cases the cervix is found presenting at the vaginal orifice, with consequent changes in the uterine axis, while in complete prolapsus the cervix and part of the body of the uterus may rest outside of the pudenda. It must be remembered that at times, when the patient assumes the recumbent position, the protruding mass recedes, and may be found resting within the vulva; therefore, in order to ascertain the full extent of the prolapsus, the patient should be directed to strain downward, or the examination should be made in the erect position. Inversion of the uterus, supra-vaginal elongation of the cervix, protruding myoma and urethracele should not be mistaken for procidentia uteri.

Treatment.—Since the term prolapsus uteri embraces such varied degrees of displacement, and is caused by such a variety of pathological disorders, the cure depends wholly upon the correction or removal of these conditions; therefore its management necessarily offers a broad field for treatment, which includes hygienic, therapeutic, mechanical and surgical measures.

Hygienic. —Women who suffer from prolapsus should be advised to observe all the sanitary requirements of dress. Clothes that constrict the waist should be interdicted. When obesity or a relaxed condition of the abdominal wall exists, a well-fitting abdominal support should be recommended. Such patients should be instructed to avoid long walks, standing upon the feet for long periods, lifting heavy weights or straining at stool. Disorders of digestion and constipation should be corrected, and such other measures as will improve functional activity in all the organs of the body instituted.

In mild cases of prolapsus, those of the first degree, where grave secondary complications have not taken place, it might, with reasonable propriety, be said that the treatment is virtually prophylactic in its nature.

Chronic endometritis, and consequent uterine engorgement, is one among the frequent predisposing causes of uterine prolapsus. When it is found to exist, it should be overcome by means of curettement, hot vaginal douches, boro-glyceride and alum tampons and electricity. If a laceration of the cervix exists it should be repaired by trachelorrhaphy, or, if extensive induration and hypertrophy accompany it, amputation of the neck should be performed. These measures greatly aid in reducing the chronic enlargement of the organ and overcoming the displacement.

Retroversion is a prolific factor in the production of prolapsus; in fact, all cases have more or less axial changes. The organ should be restored to its natural position, and, if necessary, after the tenderness has been relieved by the hot douches and tampons, a carefully fitted pessary should be applied and worn until all the hypertrophy has been removed. Electricity has a very beneficial effect in restoring the tonicity to the overstretched ligament in many of these cases. If the organ cannot be reduced, or cannot be maintained in the proper position, the surgeon should not hesitate to open the abdomen and do a ventral fixation, at the same time break up any adhesions that are present and remove existing small fibroids or diseased appendages.

Since injury to the perineum is the greatest causative factor in the production of prolapsus, it becomes imperative, as a prophylactic measure, that care should be observed in the protection of these structures during and after parturition. After every labor a critical examination of the perineum should be made, and every tear, even of a slight extent, should be repaired in the most exacting surgical manner. When an old standing injury to the pelvic floor exists, it should at once engage the attention of the physician. A developing cystocele should be overcome by an anterior colporrhaphy, and a rectocele should be corrected by a perineorrhaphy or a colpoperineorrhaphy.

When the causative pathological condition in uterine prolapsus has been corrected by surgical measures, the after care of the patient is worthy the most careful consideration of the physician. She should be kept in bed until the resulting cicatrices have become strong, and the relaxed or overstretched tissue has had time to, in some degree, regain its lest tonicity. Her general health should be looked after, and such remedies prescribed as may be necessary to correct any existing bodily ailment. Marital relations should be interdicted for a period of at least two to three months, and, where plastic work upon the vagina has been performed, a specular examination should not be made until the parts operated upon have become strong. If, after a reasonable time, two or three months, the condition is not relieved, electricity should be daily used to relieve any remaining congestion of the parts and to give tone to the relaxed ligaments. When necessary, a comfortably fitting pessary may be applied, and worn until the uterus has been reduced to its natural limits in size.

Complete Procidentia. --- In prolapsus of the second and third degrees, where there is a radical deviation in the axis of the organ, and the structural changes are so great that the tissues can never be restored to either their natural anatomical form or physiological function, palliative measures are totally ineffectual. Nothing short of radical surgical measures will give satisfactory results. After considerable experience in the management of such cases, which includes the application of many of the various methods recommended by different authors, there are but two that are, in my judgment, worthy of consideration, viz., abdominal fixation, preceded by amputation of the cervix and plastic work upon the vagina, or vaginal hysterectomy, accompanied with, or followed by, anterior colporrhaphy or colpo-perineorrhaphy. The age of the patient is largely the governing factor in the choice of the method. In young subjects who suffer from a marked degree of prolapsus, where the elasticity of structures has not been totally impaired, the abdominal operation is chosen; while in old subjects in whom senile atrophy has taken place, rendering the tissue unfavorable for perfect plastic work, vaginal hysterectomy deserves the preference.

The recital of a clinical case in either variety will probably best serve to illustrate the methods.

Mrs. A., aet. 24, German, tall and delicate, the mother of two children, the youngest three years old, suffered since the birth of her last child from progressive uterine prolapsus. She has, in addition, a marked lateral and antero posterior curvature of the spine, which greatly adds to her discomfort. An examination revealed a bad laceration of the perineum, a distended vagina and an enlarged and completely prolapsed uterus. The cervix was lacerated and greatly elongated. Both ovaries were cystically enlarged and both tubes elongated and thickened.

The woman was placed in bed, the prolapsed uterus and vagina replaced and douched with a 1 to 3,000 bichloride solution, after which a wool tampon saturated with an alum and boro-glyceride solution was applied. This treatment was repeated daily for two weeks; at the end of this time the uterus was found to be much reduced in size and the vaginal structures shrunken.

The patient was now prepared for a vaginal operation, anaesthetized and placed upon the table. The rectum was first dilated, and several large hemorrhoids removed by the Pratt method. The uterus was then dilated, curetted, and the cervix amputated high up, by the antero-posterior flap method of Schroder; after which an anterior colporrhaphy, for the correction of the cystocele, was done after the manner of Hegar as follows: The vaginal wall in front was seized in its central line by two pairs of Martin's forceps, one near the meatus and the other near the cervix; these were placed in the hands of an assistant and drawn forward, so as to put the tissues upon the stretch. With a sharp scalpel, beginning near the cervix uteri. an incision that divided the vaginal mucous membrane and muscle was carried forward on one side in an oval curve. close up to the meatus. A like incision was then made in the same manner on the opposite side, a sufficient amount of tissue being included to take out all the redundancy. Then, with a pair of sharp scissors, the loose cellular tissue which connects the vaginal muscle with the bladder was divided and the flap removed; after which the wound was closed with a number three sheep gut suture, as follows: Beginning at the meatus, a fine sharp curved needle was introduced just inside the edge of the cut surface, so as not to include the mucous membrane, and made to pass straight across the denuded surface, emerging on the opposide side at a like point inside the wound edge. A continuous or running buried suture was carried in this way down to the cervix. Beginning at this point with the same ligature, another row of sutures, that took strong hold in the mucous membrane, was carried upward to the meatus, and the two ends tied. This accurately united the divided edges of the mucous membrane and firmly closed the chasm, making a strong seam in the median line.

The rectocele was next corrected and the perineum restored by a modification of Dolores' flap-splitting colpo-perineorrhaphy in the following manner: A vaginal flap was dissected to the upper border of the perineal body, then with the index finger the recto-vaginal tissue was separated well up to the cervix, after which a pear-shaped section of the flap, corresponding with the perineal body, was cut away with the scissors. Then, beginning at the highest point at which the recto-vaginal septum was separated, a needle threaded with a medium-sized sheep-gut suture was entered into the vagina on the left side and made to penetrate the flap, carried across the space and entered the flap on its under or raw surface and brought out in the vagina on the right side. It was now again entered on the right side, one-third of an inch nearer the vaginal outlet, again passed across the space and brought out in the vagina at a like distance (one-third of an inch) from the point of introduction. A second suture was then introduced in the same manner. This made a heavy ridge in the posterior wall of the vagina and completely obliterated the rectocele. The outer part of the wound, the perineal body from which the flap had been cut away, was then closed with buried No. three sheep-gut sutures, introduced in such a way as to most accurately approximate the parts; after which the vaginal mucous membrane and the skin on the outside were coaptated by a continuous sheep-gut suture of medium size. completed the plastic work; the entire operation lasting one hour and twenty minutes. The patient was again put to bed.

and kept there for three weeks, a most perfect result following. At the expiration of this time she was prepared for a laparotomy. The abdomen was opened, the cystically enlarged ovaries and greatly elongated and thickened tubes removed, and the fundus of the uterus fixed to the abdominal wall. The attachment was made high up by rather a broad surface. Recovery was prompt and the results most satisfactory. I examined the patient two years afterward, and found the vagina to be, though small, of good contour and the uterus much reduced in size and in perfect position.

The good result in this case is typical of what I have had from many similar operations.

Case 2. Mrs. W., aet. 57; a stout German woman and the mother of six children, consulted me on account of complete prolapsus of the uterus and incontinence of urine, which had existed for several years. An examination revealed a badly lacerated perineum and distended vagina, the tissues having entirely lost their natural elasticity. A large mass, the size of a goose egg, protruded from the vulva. This hernial mass was found to contain the bladder, uterus and a cystically enlarged ovary the size of a lemon.

A hysterectomy was advised, to which the patient readily consented. Accordingly, after the necessary preparations, the uterus, ovaries and tubes were removed by ligatures in one operation per vaginam. At the same time a V-shaped section of the interior vaginal wall, with its apex at the meatus, of sufficient dimensions to include all redundancy, was made and the chasm closed with two rows (one buried and one superficial) of sheep-gut sutures. The broad ligaments were then drawn down and secured with ligatures on either side in the angle of the vaginal wound; the vaginal wound closed without drainage and the vagina was lightly packed with sterilized gauze. This union of the broad ligaments in the angles of the vagina gives it support, and as the ligaments contract causes the vaginal vault to be drawn upward, and has a tendency to overcome both the cystocele and rectocele. The recovery of the patient was uneventful. Three weeks later she was again put upon the table, several hemorrhoids removed from the rectum and a colpo-perineorrhaphy performed. Recovery was prompt. An examination made one year after showed the results to be entirely satisfactory. There had been no return of the urinary trouble, nor had there been a reappearance of either the cystocele or rectocele.

This is the method that I have adopted in the treatment of procidentia in old people, and in a number of cases operated upon I have not had a failure to record.

When patients with complete procidentia uteri decline to submit to radical measures for relief, the physician has but little to recommend in the way of palliative treatment. In fact, in old women with atrophy and loss of tonicity of the vaginal and perineal tissue, there is nothing to offer.

If the vulva is not too patulous and there remains some elasticity of the structures, some form of pessary may be applied; usually the soft rubber ring will answer best. instrument, however, will frequently escape while on the feet or when straining at stool. In these cases temporary benefit may be derived from the daily use of hot douches, massage and the application of electricity, all of which tend to improve the tonicity of structures. Wool tampons saturated with some astringent, boro-glyceride solution, snugly packed in about the uterus, will at times for a while be beneficial. Such patients should be instructed to spend much of their time in the recumbent position, and should be taught to replace the womb when lying down. In some cases some form of belt pessary, with a cup attached, in which the cervix rests, or a perineal pad supported from the waist, may be more or less constantly worn. These instruments, however, sooner or later produce abrasions and ulcerations, and must be discarded.



THE HISTORY AND LIFE-HISTORY OF UTERINE FIBRO-MYOMATA.

BY EDWIN A. NEATBY, M. D.

HISTORY.

Faulty Classification.

From Hippocrates onwards the existence of tumors of the uterus has been known; in the earliest days they revealed themselves solely in connection with pregnancy and parturition. It is not surprising that in the account of early cases moles, polypi and tumors of various kinds were mixed up, for even to-day in the museums of our hospitals and colleges traces exist of a nomenclature and classification which, though not forty years old, are nevertheless obsolete.

Galen is said to have recognized and described both "hard and soft polypi." In the eighth century Paulus Ægineta used the term "scleroma."

"Womb Stones."

Coming down to relatively modern times we find an interesting observation made by the celebrated French surgeon, Ambroise Pare, in 1562, in his treatise "De Generatione," chapter xli. He says, "There can be no doubt that just as stones form in the bladder, so they do in the womb, and the woman often has spasmodic pains as if labor would come on." Indeed, as one would expect, most of the early observations respecting uterine tumors were made in connection with obstetric medicine. For example, a case is recorded by Fabrice de Hilden, in 1646, of a woman who was in labor six days, the delivery being impeded by a large cervical fibroid. The case ended by rupture of the uterus, and at the post mortem the child's head was found in the abdomen. Such an occurrence as this was by no means rare even at much later dates than the seventeenth century.

Sterility and Tumors.

So early as 1748 Louis contributed a paper to the "Academie de Chirurgie," in which he summarily disposed of a question which is not yet regarded as wholly settled. "Sterility," he says, "is the necessary result of a foreign body

in the uterus"—"foreign body" here being intended to include tumors.

Influence of Pregnancy and Parturition.

Lefour, in 1880, presented to the Paris Faculty of Medicine a monograph on fibroids from the obstetrical point of view. He divides the history of the subject into three periods. The first period lasted to 1749, the second begins with a classical and exhaustive article by Levret in the "Memoires de L'Academie de Chirurgie" in that year. Besides giving the diagnostic features of fibroids from a variety of other conditions, he, more than any one else of the period, brought forward the method of ligaturing fibrous polypi. He also pointed out the influence of pregnancy in causing a rapid and considerable enlargement of these tumors, while the Englishman, Ashwell, in 1836, adduced evidence to show that these tumors may after delivery undergo rapid softening-in some cases amounting to gangrene. In view of this, he advised as a regular practice the bringing about of artificial delivery in order to prevent such an accident. At the same time, an opposite, or, at least, modified view was adopted by the Edinburgh School of gynaecologists, as represented by the writings of Ingleby, who restricts the induction of abortion to a definite set of cases.

Polypi and Fibroids.

In looking over the early English works on diseases of women one finds that the identity of hard polypi and fibroid tumors ("fleshy tubercles of the uterus") was not soon or uniformly recognized. Clarke, writing in 1814, describes the hard polypus as "an insensible tumor projecting through the os uteri," and gives signs to distinguish it from inverted uterus and "cauliflower excrescence." He fully describes the operation by ligature, stating that from 4 to 12 days are required to complete the separation of the pedicle; "it sometimes happens that the ligature and cannula fall out of the vagina when the practitioner is not present; for which event the patient should be prepared lest the occurrence should cause alarm." Ordinarily, "after the neck of the tumor is destroyed," the operator has to remove it. The same author, writing on "Fleshy Tubercle," states that "if colored injection be thrown

into the vessels of the uterus, so as to make the substance of the uterus quite red, none of it passes to the tumors of fleshy tubercle." This was an opinion which lasted for a number of years, but later investigations showed it to be possible in many cases to inject even hard fibroids. It is nevertheless relatively true, hard fibroids being nourished from their capsules and containing very few demonstrable vessels.

That Clarke was an accurate and careful observer many of his statements show; for instance, he states on the authority of his own experience that in cases of fibroids "the os uteri may at the same time be afflicted by the corroding ulcer," that is, by carcinoma—a fact which later writers for a time denied. He also had seen the combination of "fleshy tubercle, the corroding ulcer and dropsy of the ovary," a combination sufficiently rare to be worth recording. A clinical symptom of value mentioned by him also illustrates the same care. Regarding the sense of downward pressure caused by these fibrous tumors, he says, "This will not be much relieved by the horizontal posture, as in simple cases of prolapse." The various pressure symptoms due to fibroids have long been known and various procedures for their relief described. Terminology.

By the name "scirrhus," "tubercular scirrhus," or "scirrhous tubercle," Dr. Blundell, in a lecture on "Diseases of Women," at Guy's Hospital, describes the tumors now known as fibroids, or fibro-myomata. They vary, he states, from the size of a pea to that of a nine month's pregnant uterus. He says. however, that the disease is not confined to the womb, but may extend not only to the neighboring pelvic organs, but "in rarer cases the liver and lungs themselves are included in the disorganization," here evidently confusing the disease with some form of cancer. Blundell makes an observant remark respecting the earliest stages of so-called "scirrhus," when he says that it is the tumors not bigger than the foetal head which cause many distressing symptoms, that is, they rather than larger ones situated in the abdomen cause these discomforts. In this modern clinicians will fully concur. The same author says that there is little to be done in the way of treatment, and that very active remedies are not advisable.

By active remedies he means "much purging, copious doses of mercury, conium, and other remedies of the kind." Palliatives, in the shape of leeches, fomentations and anodynes are advised. When giving instructions for the removal of uterine polypi he cautions the operator against including any portion of the womb. "This misfortune will cause additional pain, although the woman may recover." He had by ligature extirpated the whole uterus.

Gynecology.

(The term "gynaecology," though of fairly modern use in English works, dates much earlier in German medical terminology. In 1828 a "Lehrbuch der Gynakologie" was published in Leipzig by Carl Gustav Ceros. This work, however, includes a complete obstetric treatise.)

In 1856 Wallis wrote that nbrous polypi lessen the number of conceptions and increase the number of abortions. From about this time, or a little later, the study of uterine tumors apart from obstetrics tooks its rise, and has formed a theme for an enormous number of writers, both clinical and, especially latterly, pathological.

Surgical Treatment.

The surgery of fibroid tumors has advanced by leaps and bounds during the last twenty years. In 1877 Erichsen's text-book of surgery does not refer to the removal of the uterus and tumor by laparotomy for this disease as a practicable This is sufficient to show that, although the operation. question had been raised, and was occupying the attention of abdominal surgeons and of the representatives of the newly developing specialty of gynaecology, hysterectomy for fibroids had not become an operation recognized by general surgeons. In 1878 Robert Barnes, in his second edition, discusses the value and place of local styptics, dilatation and incision of the cervix, enucleation, treatment by the actual cautery ("igneous hysterotomy"), and so-called "normal ovariotomy" (removal of the uterine appendages). Only a few years previously Battey had proposed, and was then (1877-1878) carrying out, the last mentioned procedure for reflex neuroses. In 1876 and 1877 Trenholme and Hegar had applied his ideas to uterine fibroids, and Tait did this operation as early as 1872.

Barnes regarded the operation as still sub judice, and remarked that it was perhaps premature to condemn it absolutely! He gives more space and support to the earlier mentioned forms of treatment, especially commending from his own experience incision of the cervix. An imperfect description of removal of the myomatous uterus, which apparently he had not performed himself, is given.

Hysterectomy.

Nevertheless, a few operators had been at work; the earlier cases of hysterectomy were done by surgeons who encountered uterine fibroids when undertaking operations for supposed ovarian tumors. These were mostly fatal. Nevertheless the feeling forced itself upon the profession that hysterectomy was not only a justifiable but a necessary procedure, and as antisepsis and asepsis became more certainly obtainable, its success was secured. As was the case with ovariotomy at first, the stump or pedicle was first treated extra-peritoneally. Even now some of our most successful English operators still advocate and practise this method. The disadvantages of a sloughing pedicle in the abdominal wound have led to attempts being made to do away with the extra-peritoneal treatment by strangulation of the pedicle. Ligaturing the uterine arteries and stitching peritoneal flaps over the uterine stump, after trimming it, accompanied by return of the stump into the pelvis, has been practised with more or less success in England and on the Continent. But recent German writers go farther, and carry out total removal of the uterus, including the cervix, operating either entirely from above or by the combined vaginal and abdominal routes. Into the endless minutiae of variety devised by different operators it is undesirable to enter here. Nor can one state that there is a fixed percentage of success to hysterectomy as a whole for fibroids, or to any particular form of that operation. Rather must it be said that each operator has his own mortality rate, and each decade of any given operator has its own average, the death rate in the earliest years, of course, being greatest. Exceptional cases always crop up to interfere with any average. statistics give a mortality of about 30 per cent., but this is above the average of the last few years. Thomas Keith is said

to have attained a mortality of only 8 per cent., while in any recent series by men like Tait, Thornton and Bantock the results are not worse than this. From 15 to 20 per cent. may be roughly suggested as a fairly probable average for grouped operations.

Enucleation has now few advocates; it is almost abandoned. I have never seen it practised in the London Homoeopathic Hospital.

With this brief sketch of the history of fibroids I will pass on the the second and more practical part of my subject.

THE LIFE HISTORY.

Earliest Naked-Eye Appearance.

The earliest stage in the life of a uterine fibro-myoma which is discernible to the naked eye may be said to be a small discrete body, oftenest observed embedded in the substance of the uterine wall, quite distinct in appearance from the muscular tissue, and projecting slightly above the level of the cut surface. Such a minute fibroid is shown in a uterus from which the accompanying drawing (see Fig. 1) was taken. It may be described as about the size of a small pea. On examination such a tumor is seen to be complete and fully developed, though small and not fully grown. It may not unfittingly be compared to a newly born babe, complete in all its parts, and on the threshold of its life, with capacity for growth, and the prospect before it of subsequent decay. As the embryologist has studied the prenatal stages of the infant, so the inquiring mind of the pathologist has sought to observe (or, failing that, to imagine) a previous stage in the development of fibroids to the one alluded to. The earliest theories, such as Velpeau's, advanced to account for the origin of these neoplasms, were those of local irritation, such as (1) effusions of blood, or (2) of "plastic lymph," or (3) of small collections of pus, which were supposed to serve as a nucleus. The effused cells were supposed either to proliferate, and themselves form connective tissues, or to act as an irritant, which stimulated the overgrowth of the tissue normally present.

Professor J. C. Wood, of Cleveland, whom not long ago we had the pleasure of welcoming as a guest to this society,

very justly remarks: "That there is exaggerated local nutrition is unquestionable. But just why exaggerated local nutrition should in one instance produce fibroma, in another myoma, and in still another simple hyperplasia * * * * it is hard to determine." Another American author states simply that

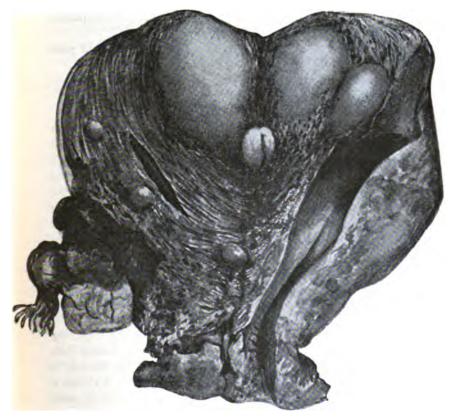


Fig. 1.

Multiple Myomata, showing early stages of growth.

"microscopical examination shows that fibroids originate from capillaries which are undergoing obliteration." The prime cause of any vital change seems impossible of discovery. Why should these capillaries undergo obliteration? The latest

systematic writer on the subject, Haultain, of Edinburgh, mentions that some speculators state "that they have found bacterial growth acting as a cause," a statement lately disproved by Marey. Haultain frankly admits that "the actual histogenesis has yet to be proved." For practical purposes we may be content, for the time being, to allow this to remain.

Congenital Origin.

But there is another group of theories, differing in detail, but having an evolutionary basis, which from their novelty and interest demand notice. Cohnheim advanced a suggestion, unsupported in the onset by any evidence of a demonstrable kind, that tumors may "spring from unutilised fragments of tissue or 'residues,' some of which may be due to faults or to embryonic irregularities." Bland Sutton arranges tumor germs into two classes—"vestiges" and "rests." "Vestiges" are the remnants of organs which in lower animals are active; of organs which atrophy after birth, e. g., the thymus, and of some which, while represented in both sexes, are only active in one. From none of these classes can fibroid uterine tumors be said to derive a "germ" which develops into a neoplasm. "Rests" is a term which is reserved for "detached fragments of glands and isolated portions of tissue and epithelium." By more pathologists than one it has been surmised that these "rests" may form one cause, at least, of uterine fibroids. It will be remembered that in most of the lower mammals the uterus is practically a double organ, consisting of two muscular tubes. In the human female the two tubes are fused, forming one central organ. Myomata of the uterus are, perhaps, the most frequent tumors of a woman's sexual organs, while these growths are practically unknown in the Fallopian tubes, or even in bicornuate uteri. Bland Sutton observes that these facts "would seem to favor the view that uterine myomata may in some cases arise from "rests" in the uterine walls, due to imperfect coalescence in the embryo.

This theory of the congenital origin of at least some uterine fibroids requires, it is true, further proofs before final acceptance. As regards the womb, there still remains an unfortunate absence of microscopic proof of the connection between embryonic "rests" and neoplasms which develop during adult life. In support of this theory, however, are the facts that the prostate in the male, the homologue of the uterus in the female, is the seat of similar growths, and that here more evidence of their vestigial origin is forthcoming. Similarly regarding the associated gland—the breast—innocent neoplasms, fibro-adenoma and simple adenoma have been traced to congenital sources.

Leith Napier draws attention to the investigations of Arthur Johnstone respecting the hyaline layer of the blastoderm, "the matrix of all epithelial tissue." As the result of irritation of this layer, there are formed connective tissue cells instead of the natural glandular or secreting cells, which new abnormal cells correspond with the round cells of Kleinwachter, found in connection with the capillaries. These round cells "undergo transformation into fusiform bodies, and become grouped together."

Biological Causes.

Before leaving the etiology and taking up the more practical and clinical side of the life history of fibroids, it is desirable to spend a short time in studying the cause from what may be termed the biological side, rather than the anatomical, which has already been referred to. The first point to be determined here is the age of the patient—or, more accurately, the period of the sexual life of woman—at which these growths most commonly manifest themselves. Fortunately here there is practically no divergence of opinion. It is proved beyond dispute that uterine fibroids arise in women during the period of actual sexual life, that is, between the first and second climacterics. Before puberty and after the menopause their origin is practically unknown. The youngest authentic case I have come across was a girl of 17 years, and even here there appeared to be present a distinct myxomatous element. It was reported at the Obstetrical Society. The tumor grew from the cervix. The few cases on record which appear to be exceptions to this rule are so incompletely described as to make the diagnosis inadmissible.

Sterility and Fibroids.

The next question for discussion is much less easily settled—indeed, it is still a subject of controversy—viz., as to what

effect marriage and celibacy have on the production of these growths. In this connection it must be borne in mind that woman stands practically alone amongst the female mammals. With the exception of some of the higher apes and baboons, woman is the only female animal who has recurring monthly hyperaemia of, and haemorrhage from, the genital organs. It is, of course, the hyperaemia, and not the resulting haemorrhage, which concerns us. Again, in nature, all animals pair, and the females fulfill their physiological object by reproducing the species. The uterus is occupied with its normal function of gestation. In women, then, there is more persistent functioning of the sexual organs preparatory to reception of the fertilised ovum, combined with a much less frequent attainment of the physiological object of the functioning and hyperaemia. Along with this go the facts that women suffer largely and, as civilization advances, increasingly, from fibroids; that women of the well-to-do classes, who are more in the habit of limiting the size of their families than are the poor, suffer in an excessive proportion, and that these tumors are almost unknown in the uteri of the lower animals. This last statement is supported by Bland Sutton, and by my own researches through veterinary works and journals, and the records of comparative pathology. It has been stated that the African race suffer more from fibroids than the white women, but later facts seem to prove that until the African woman is brought under the influence of civilization and is subject to its restraints in sexual matters, she is freer from uterine fibroids than her white sister. The African woman of North America, then, under the restraints referred to, is found to suffer very frequently from fibroids. To sum up, uteri subject to less frequent stimulation (as the lower animals) or subject to frequent stimulation (as in primitive races), but occupied with the physiological process of gestation, become only seldom the seat of myoma. Respecting the relations between fibroids, celibacy and sterility Hofmeier reports 212 cases, all of which were under his own observation.

His figures show that of these patients only 43 were single women—roughly 20 per cent., or 1 in 5.

The married women bore 448 children, or an average of about 2.27 each.

With a view to forming an independent opinion, I have so far collected facts from 60 patients who have been observed by myself. My figures differ considerably in one point from Hofmeier's. The single women numbered 20 out of 60, over 33 per cent., I in 3, as compared with I in 5 in Hofmeier's cases.

The average of children was 2.25 each, and the average duration of sterility before coming under observation was 7½ years. I am inclined to view sterility as an agent predisposing to the formation of fibroids; while, on the other hand, I cannot refuse to recognize that, once present, fibroids are themselves a cause of lessened fertility.

Situation of the New Growths.

I said that the earliest naked eve change was a minute t mor embedded in the substance of the uterine wall. If this statement conveys to your mind the impression that all these growths commence as interstitial fibroids, it will faithfully represent the prevailing, and even the most modern view of their site of origin—a view definitely supported by the writer in Playfair's System, who writes (page 567): "All fibro-myomas originate in the muscular layers of the uterine wall." Again, in "Veit's Handbuch der Gynakologie" Gebhard, of Berlin, states similarly that "the original seat, both of subserous and of submucous myomata, is always intramural." In characterizing these statements as views, I do so intentionally, because, though they are plausible, I have met with no sufficient evidence to enable me to feel confident that they are founded on fact. Not only is it difficult to make actual observations at so early a stage as is essential to establish the point, but it may be impossible to settle the question in all cases on account of anatomical considerations. The deeper layer of the endometrium, the muscularis mucosae, is practically continuous with the general uterine parenchyma. In the very nature of things, then, it may be impossible to say that a tumor arising in this position starts either as interstitial or submucous. less is this so with a growth arising near the surface. peritoneum contains a stratum of unstriped muscle. Consequently Bland Sutton seems to be pathologically accurate when he states that myomata may arise in three situations, (a)

in the uterine parenchyma (interstitial); (b) in the muscular tissue of the mucous membrane (submucous); (c) in the muscle tissue immediately beneath the serous membrane (subserous). If it be granted that the origin is interstitial in any given case, the tendency is for the small nucleus to excite contraction of the muscular fibres and expel the intruder in the direction of least resistance. In the uterus which I have already referred to there is seen one tumor becoming submucous (see Fig. 1).

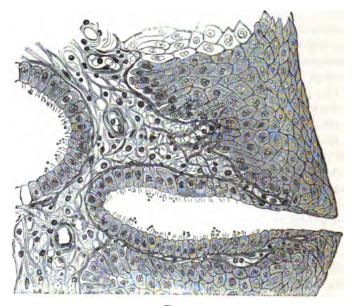


Fig. 2.

A layer of mucous membrane only covers its inner aspect. As growth increases and pressure continues, the tumor may become pushed through the wall externally, carrying some muscular and some peritoneal tissue with it to form a pedicle, until a pedunculated fibroid is found, attached only by a more or less slender stalk to the uterus. Or the same force acting in another direction may press the tumor into the cavity of the uterus, forming a fibroid polypus. The pedicle here consists of muscular and mucous tissue, with the latter of which the tumor is covered. As the mucous membrane is irritated in its passage

downward, its covering of epithelium, from being cylindrical and ciliated, may become not only squamous but stratified, and, if protruded externally, horny like the epidermis. In Fig. 2 this stratification of the epithelium is well shown. The drawing is taken by permission from Bland Sutton. While the epithelium is thus altered, the glandular tissue of the tumors which become wholly intrauterine undergoes simple hyperplasia, chiefly of its glandular elements, but also of the connective tissue. The deeper layers of the mucosa are chiefly affected. Clinically these changes are represented by an increased watery and mucous flow, most commonly complained of by myoma patients, and to a slight extent by an increase of menstruation.

Effect on Muscular Tissue.

The first tendency of a myoma is toward hypertrophy of the muscular substance of the uterus, but this is modified by a variety of circumstances. On the muscular substance a myoma has less and less effect the more it becomes a subserous tumor with a pedicle. The presence of a large number of intramural fibroids of a moderate size or of one or more large ones usually causes stretching and atrophy of the uterine wall. (A specimen handed round of a single moderately sized interstitial fibroid, which was removed by the author at the London Homoeopathic Hospital, and mounted by the Clinical Research Association, was a good illustration of this thinning.) When a tumor is submucous, and especially if becoming polypoid, or being an actual intrauterine polypus, the muscular tissue is usually decidedly hypertrophied on account of the frequent expulsive efforts made by the uterus to get rid of its contents. Some degree of hypertrophy may be seen in the case of a uterus shown in Fig. 3, where there are multiple nodules in the wall and a polypus in the cavity. Although the small tumors are crowded together, yet there is still in some places a thick layer of muscle left, especially round the uterine cavity. Effect on the Ovaries.

When the abdomen is opened for operation for fibroids, it is sometimes found that the ovaries are so tightly crushed against the pelvic wall as to be apparently atrophic. Such a condition does not, however, usually prevent them from



Multiple Fibroids, from photograph, showing thickening of muscular wall around uterine cavity.



Fig. 4.
Associated Uterine Fibroid and Ovarian Cyst.

functioning. Unless the ovaries suffer by pressure, they are very commonly larger than would be the case were no myoma present, i. e., larger than in other women of the same age. (See Fig 6.) It was the size of the ovary and tube which attracted Lawson Tait's attention and led to his practising their removal as an experiment. He, it is true, regarded them as diseased, and has expresed the view that disease of the appendages is an active factor in the production of uterine myomas. On this ground he began removing them.

But the condition I refer to here is one of hyperactivity and hypertrophy, due to to the increased blood supply to the parts, and is to be regarded as a result rather than as a cause. Secondarily, they may react and keep up the growth of the tumor.

Inflammation of the appendages is a not infrequent result of fibroids, sometimes ending in pyosalpinx. I have myself seen cases of both hydrosalpinx and pyosalpinx associated with fibroids. Ovarian cysts may also be present. Fig. 4 (4,607A, R. C. S.) is an example of this. The patient had very few local symptoms, and died afterward of acute bronchitis. Situation.

Most uteri have multiple tumors, and may present examples of two or three varieties of situation. Some drawings illustrating these varieties are reproduced here. (Specimens removed by operation were on the table; other photographs were shown by the lantern.)

Fig. 5 (4,615A) is a photograph of a large polypus with a broad base ($5\frac{1}{2}$ in. x $1\frac{1}{2}$ in.) attached to the fundus and posterior wall, taken by permission from the Royal College of Surgeons. An intramural, but almost submucous, nodule is seen in the anterior wall; the adjacent organ is the bladder. This woman, aged 40, had her ovaries removed for metrorrhagia she died on the twelfth day from "syncope."

Fig. 6 shows another fibroid (intrauterine) polypus with a small pedicle. The large size of the ovaries is notable.

Fig. 7 is photographed from a tumor which on removal weighed 8 pounds. The multiple nodules, some very large, are seen, but the most remarkable feature of the specimen is the extremely firm, hard, striated section of the large tumor.



Fig. 5.
Intrauterine Fibroma, forming polypus with broad base.



Fig. 6
Fibroid Polypus, with small pedicle

It cut almost like cartilage, and the cut surface was as smooth as and firmer than a potato. The fibrous striae are also well seen. The patient was a young woman, age 33, under my own care for some years. Progressive growth being demonstrated, she was advised to have the tumor removed. Recovery was easy.



Fig. 7.
Showing extremely smooth, hard Tumor.

Fig. 8 (4,597, Royal College of Surgeons) is a specimen of some interest; what is seen is an inversion of the fundus uteri, in sampe not unlike a polypus. Bristles are projecting from the uterine ends of the Fallopian tubes. Inversion was produced by or associated with an intrauterine fibroid, which was removed by operation, and is consequently not shown. (From the Royal College of Surgeons' Museum.)

Fig. 9 is an illustration of a somewhat unusual position for a fibroid, and especially for one of so large a size (by permission from the Royal College of Surgeons' Museum, 4,614). From the anterior lip of the cervix hangs a large tumor with a thick pedicle. It was separated by ligature and sloughing; this causes the shaggy appearance of the posterior surface. Adhesions apart, subperitoneal tumors, despite their occasional enormous size, are the least noxious of any. Referring to adhesions, they may be so complete as to nourish the tumor apart from its original pedicle. (A lantern slide was exhibited.

4,642 R. C. S., showing a large tumor with portions of intestine, mesentery and omentum attached. It was found loose in the abdominal cavity, but had probably been detached from the uterus. The growth was 7½ in. and 3 in. in diameter. It was infiltrated with yellow, hard, earthy substance, indicating calcareous degeneration.)



Fig 8.

Inversion of Uterus produced by Fibroid Polypus.

In a similar way, by adhesion and by subsequent detachment from the uterus, the Fallopian tube sometimes gets credited with fibroids, as in a case reported in the "Obstetrical Society's Transactions" for 1894 (p. 42). In reality, fibromyoma of the tube is of extreme rarity.

The relation between site and locality and the symptoms and progress is real and direct.

Interstitial Growths.

Interstitial growths come, in every sense, between the other two varieties. They are more likely to cause enlargement of the uterine cavity, and more likely therefore to be accompanied by excessive menstruation.

Submucous Growths.

Submucous growths, especially if polypoid, cause more pain, chiefly of an intermittent and expulsive character, and still more haemorrhage. This is especially the case while a fibroma is becoming polypoid. After it is well pedunculated and perhaps projecting into the vagina haemorrhage may lessen. Fifty years or more ago it was remarked with reason



Fig. 9.
Pedunculated Fibroid of Cervix Uteri.

by Lee that the source of the bleeding in these tumors is not the whole substance of the tumors or of the uterine tissue, otherwise the larger the tumor the more the haemorrhage, which is far from being the case. The next most likely source for bleeding is an extended endometrial surface, and in some degree that may be accepted as a vera causa. But, as is well known, neither of these sources is adequate to produce the excessive loss of blood, which is one of the most dangerous accompaniments of fibroids. The actual vascularity of a hard

fibroid is not great, as I have already mentioned; that of the uterine parenchyma and of the endometrium is in proportion to their development. Even with an enormous tumor neither walls nor cavity may be notably enlarged.

The blood vessels of a fibroid nodule ramify in the capsule, where both arteries and venous sinuses are found. injection by coloring matter is not easy, and after removal almost impossible, but this colored drawing (which was handed round), which is a well-executed representation of the injected original, illustrates the statement I have made. Except in the capsule, the vessels are mainly capillary. The cut ends of the capsular arteries and the open mouths of the veins are visible in the drawing. The nearer these vessels are to the uterine cavity, where they have less support, the more strongly contraction of the muscular walls tends to force the tumor into the cavity, the more they are first stretched and then torn. is this tearing of the capsular vessels which causes the enormous haemorrhages not seldom met with in fibroids, amounting oftentimes to veritable floodings, blanching the patient and inducing syncope.

It cannot be too clearly borne in mind that a fibroid tumor carried about is a continual menace to a patient's safety, and sometimes to her life. Though it is usually possible to see if a case is going from bad to worse, and to counsel active treatment on account of haemorrhage, the bleeding is sometimes sudden and dangerous. Not three months ago a patient (sent me by Dr. Molson), who had been under observation for some time for multiple fibroids, with considerable menorrhagia, returned to me after a short interval. She was previously a strong, erect, healthy-looking woman, so well that I could not advise her to submit to the risk of operation, especially as the usual date of the menopause was within sight—she was 48. She had a sudden, severe flooding, which changed her into an aged, blanched, feeble and stooping old woman.

It is only to be expected that haemorrhage should be especially severe at the menstrual period. The periodic hyperaemia of the tumor is often so great that not only do the patients state the abdomen is enlarged just before and during the first days of menstruation, but an increase in the size of

the tumor is demonstrable by measurement. So evidently may this be the case that on one occasion I have fallen into the error of supposing that a tumor was becoming reduced by treatment on account of the difference between a pre-menstrual measurement and that taken some months later, soon after a period.

Pressure Symptoms.

Cases are recorded where the hyperaemia of menstruation has so enlarged a fibroid occupying the pelvis that impaction has occurred, accompanied with so-called suppression of urine and intestinal obstruction. Slighter degrees of this are quite common. For instance, in a patient recently sent to me by Dr. Vincent Green, where the tumor well filled the pelvis, on two occasions just before the onset of menstruation retention of urine took place. The pressure may be on the neck of the bladder or on the ureter at the pelvic brim. When but slight the depletion following on the onset of the period soon relieves the pressure. In no case is true anuria or suppression present unless, possibly, in association with a twisted pedicle and gangrene.

Growths of the uterine wall may induce either retention by pressure on the urethra, or incontinence or pyknuria due to the drag on the bladder by the upward-growing tumor. Unless the pressure is considerable or frequent, kidney damage does not occur; but nephritis (pyelitis), hydronephrosis and pyonephrosis do occur, and cases are reported where these conditions have been cured by the removal of the tumors.

Constipation due to pressure is less frequent than one would expect. It was only present in a small number of my own cases, and in none was it serious. This, of course, is only due to the fact that most frequently a large tumor rises out of the pelvis and relieves the pelvic organs to some extent of pressure. Haemorrhoids are not seldom present, and become a source of considerable discomfort.

Rate of Growth.

All efforts to estimate the average rate of growth have failed, and no average could be of use in prophesying the rate in any particular case. It has been said that a tumor the size

of "an egg" or "a man's fist" or "a foetal head" represents a year's growth. But all such statements are misleading. In any individual case only by watching can its rate of progress be determined. The rate of growth is determined partly by the nature of the growth. Soft or oedematous myomata grow more rapidly than hard fibroids. The more pedunculated a fibroid becomes, the less rapidly is it liable to grow, on account of the lessening of blood supply. This is true both of intrauterine and subperitoneal growths.

The rate of growth is, ceteris paribus, quickest in young subjects, e. g., by the age of 28 Mrs. O. had a large multiple tumor well above the umbilicus.

Miss W., age 28; in summer of 1894, menorrhagia was present and a slight general enlargement of the uterus was found; no tumor was demonstrable. In less than a year it had grown to the size of two fists, and was removed by hysterectomy.

In the case of E. W., in 12 months a tumor grew from the size of a walnut to that of an orange; this patient was 31 years of age.

Miss C., on the other hand, first discovered a tumor in 1887; she was then 43 years of age. This steadily grew for some seven years, and even then it reached only half way to the umbilicus. Menstruation persisted excessively all this time.

Even between the ages of, say, 25 and 35, the rate of growth is usually leisurely, so that months are occupied in bringing about any conspicuous increase in size.

I believe also, though I am not able to prove it, that the rate of growth is relatively less in a large tumor than in a small one. By measurement it is not easy to establish this, but it is certain that a large tumor often remains stationary for months and years, while this never occurs, in my experience, in small ones. A tumor in a woman who became insane after its disappearance took nine years to attain the size of a foetal head. It disappeared in less than three. (Tait.)

As a rule, however, small fibroids attract but little attention. For this reason we have but little information as to rate of growth. This is especially the case with subperitoneal tumors, and even interstitial growths seldom give trouble, unless

situated low down in the uterine wall. In this situation pressure on the neck of the bladder may induce either painful and difficult or frequent micturition.

Should a rapid increase in size attract attention, this is in most cases an indication that some change other than mere growth is going on. In young and middle-aged subjects this is usually due to cystic degeneration. An example of this is seen in a specimen (shown on the screen, 4,643C) taken from the Museum of the Royal College of Surgeons. Here the tumor was so large that it reached the ribs, and only seven months before operation was it first noticed. This patient was single and aged 29.

In the case of "E. B.," which I have reported elsewhere, the cyst on the surface of the tumor rapidly increased, as evidenced by measurement in a few months. (The tumor was exhibited.) **Diagnosis.**

Hard myoma may be so easy of diagnosis that it is only necessary to place the hand on the abdomen to be assured of the nature of the case. At the other extreme comes the cystic myoma, which offers more difficulty in diagnosis than any other form of uterine or even pelvic tumor. Its resemblance to some forms of broad ligament cyst, where the uterus is drawn up and is out of reach, is so great as to defy differentiation. Cases have occurred where a solid tumor has become riddled with evets, and conveying the sense not only of encysted fluid, but of sclid elements more or less mobile therein, and plainly felt on This, together with enlargement of external ballottement. breasts, deposits of pigment in the middle line of the abdominal wall, blueness of the vagina and amenorrhoea, may cause a striking and embarrassing likeness to pregnancy. In this connection a pathological curiosity may be worth mentioning from a possible medico-legal aspect. Large fibroids, especially if rapidly growing, produce lineae atrophicae in the skin of the abdomen, as does pregnancy. Forcible delivery of a uterine fibroid polypus has caused rupture of the cervix and perinaeum. This combination has led to forensic disputes. For the rest, as to differential diagnosis, I do not propose to dwell on this, beyond remarking that it has always appeared to me that the

main difficulty is usually one of establishing facts and not of their interpretation.

Difficulty is one of Establishing Facts.

Since the day when Lisfranc believed the "contents" of a fibrous tumor to be "plastic lymph," when Levret compared it to "the baked teat of a cow," and M. Roux thought it resembled the intervertebral cartilages of old men, some advances have been made in the pathology of "fibro-myomata." Broadly speaking, they are known to consist of fibrous tissue and muscular tissue in varying proportions and differing a rangements. Such differences will seem to account for the variety in the consistence of the tumors, and to some extent in the rate of their growth. But the feelings of those most intimately acquainted with uterine fibroids is that under this term are included distinct varieties of tumors, and that the study of clinical histories, together with the microscopic structures, will ultimately enable observers properly to classify them.

Taking one extreme, where fibrous tissue predominates, we get the hard fibroid, or fibroma. At the other end of the scale comes an excess of muscle tissue, and we get the "soft fibroid," or myoma. Myomata are most frequently devoid of capsules, while hard fibroids are commonly encapsuled. (Some microphotographs were here shown to demonstrate the minute structure of fibroids in comparison with uterine tissue.)

Decadence.

Having followed the life history of fibroids from their earliest known origin to maturity, we have next to consider their decadence. Like that of their hosts, their history is very diverse. Maturity is arrived at in different individuals at very different ages, and their later years are characterized by a variety of vicissitudes. In some instances the event proves that they have, in Transatlantic phraseology, "come to stay." It may be regarded as a work of supererogation to attempt to prove this, but I shall do so. In some circles there seems to be the feeling that these growths are not only "innocent" in the technical sense, but wholly innocuous, or at most that they cause only occasional inconvenience from their weight, and that these temporary disadvantages and the tumors themselves

vanish like snow before the sun at the benign approach of the menopause.

Mrs. K., aged 65, had had a multinodular fibroid, for many years unrecognized. She had passed the menopause some years. The tumor extended midway between the umbilicus and ensiform cartilage. She had mitral disease, but was able to get about without special dyspnoea or cardiac symptoms. A slight attack of bronchitis came on, and became first serious and then fatal. I came to the conclusion that the embarrassment to breathing and to the circulation caused by the tumor contributed distinctly to her death.

Mrs. W., aged 52. Menstruation ceased at about 46. The tumor extended nearly to the margin of the ribs on the right side, and was (as the exhibited specimen proved) of considerable size and remarkable solidity. Six years after the climacteric it had not lessened in size. Moreover, the pressure on the veins of the pelvis caused a persistent varicosis and a state of varicose eczema of the legs. The weight and discomfort of the tumor caused progressive disability and emaciation, so that 15 months ago she readily consented to operation. That the tumor was to blame for most of the trouble is proved by the fact that she is earning her living, is gaining flesh, and is much less troubled with the leg.

Miss B., aged 65, came to London, begging for operation. The menopause took place at 53 years of age. The tumor has remained stationary. When I saw her it extended to the right ribs, nearly to the left ribs, and in the middle life half way between umbilicus and sternum. Patient walks about the house with difficulty, and after a short walk out of doors is obliged to keep her bed for a day or two.

These examples—all drawn from the last two or three years of my practice—are enough to show that the menopause may occur without causing any diminution in the size of these growths. Without committing myself to any definite size limit, I would say that in long-standing hard fibroids which extend above the umbilicus it may be asserted that the menopause will not usually exert any notable lessening influence upon them. In the case of soft fibroids the probability becomes a certainty.

Another and more satisfactory termination for fibroids is in resolution. At one time it was thought more necessary to prove an assertion of this kind than the contrary. The pendulum has now swung to the other extreme.

Absorption.

Doran is of opinion that absorption is the usual and regular termination of fibroids which have lasted until the menopause without killing the patient or undergoing active degenerative changes. That this is actually so in the majority of cases may be true. The fact that we have no statistics to prove it may be regarded as an evidence of its truth, for patients cured, whether by nature or art, are rapidly lost sight of. It is proper to state that in rare instances atrophy occurs before the menopause. There is a growing tendency among modern gynaecologists to realize that, whatever be true of the majority of cases, there is an important proportion of tumours which do not pass on to a peaceful and natural "death."

The theory that atrophy of fibroids is preceded by oedema has been advanced chiefly on speculative grounds, because it is supposed that a tumor so softened will be more readily absorbed. The decree of the oedema necessary to be of value in facilitating absorption would so visibly enlarge the tumor that it would not pass unobserved. Clincically such enlargement is not a usual precursor of atrophy. Œdema is due to venous obstruction, atrophy to diminished arterial supply. The larger a fibroid and the longer it has lasted the less likely is it to disappear spontaneously.

Fatty Degeneration.

That fatty changes are an accompaniment of atrophy is not unlikely, although it must be confessed that under other circumstances fatty degeneration is uncommon.

Cysts.

A much more common change in these tumors is the formation of cysts, and this takes place more frequently in soft fibroids and in subserous, pedunculated tumors. It occurs during active sexual life, and also constitutes one of the causes of post-menopausic activity and enlargement of fibroids. Edema is the first stage in the formation of fibroid cysts. Clinically it is accompanied by enlargement of the tumor,

Uterine Fibro-Myomata.



which goes on even more rapidly as the cyst formation becomes defined and fluid accumulates. Cystic fibroids are uninfluenced by the menopause, and tend rapidly to destroy life. Pathologically they are intimately associated with mucoid degeneration of myomatous tissue, though it is not certain they may not originate without such degeneration. Some of these cysts have an endothelial lining, but in others no lining is present. Figure 10 (4,643) is taken from a cystic myoma.

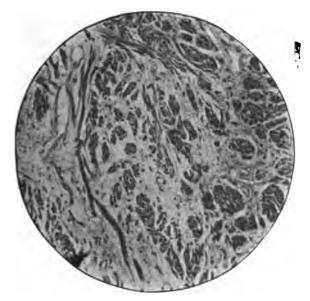


Fig. 10.

Section from Cystic Myoma, showing rod-like cells and nuclei.

It shows the long muscle cells, with rod-like nuclei. The fibrous tissue cells occur in little groups or singly, embedded in a large quantity of connective tissue, which at times is dense and homogenous, and at times wavy and of loose texture. (Micro-photographic slides were here exhibited, to show changes associated with hyaline and commencing mucoid degeneration.)

At the Medical and Chirurgical Society, in 1893, Doran gave three modes of origin of these cysts in benign myomata; they were:

- (1) Breaking down of solid tissue from fatty or mucoid degeneration, or from local necroses (Uter).
 - (2) Dilatation of blood vessels or blood sinuses.
 - (3) Dilatation of lymph channels.

Lymphangiectasis, he said, was probably more frequent than hitherto believed, and obstruction of the lymphatics outside a tumor was very frequent.

Mallgnant Change.

I use the expression "benign myomata" because the next change to be mentioned as being intimately associated with cystic fibroids is sarcomatous degeneration. This is a change to which both soft (diffuse) and hard (encapsuled) myomata are subject. A case of my own, removed in 1895, shows one large cyst, which occupied the anterior surface of a soft myomata which had undergone sarcomatous change. The woman was about 39; it was first noticed only about a year before I first saw her. Recurrence is taking place (1897), but life is still much more bearable than before operation.

Dr. Burford kindly allows me to mention a case of myoma, at the removal of which I had the pleasure of assisting him. The fibroids here were multiple, and so were the cysts. The microscope revealed sarcomatous degeneration.

Sarcoma is the only form of malignant change to which fibroids are subject, though carcinoma may arise in another part of a myomatous uterus. Figure 11 shows a tumor of the uterus (myoma) which has undergone sarcomatous change; it has infiltrated the uterine wall, and is seen growing into the broad ligament. It is one of John Hunter's specimens in the Museum of the Royal College of Surgeons, and there is no clinical history attached. Figure 12 shows the micrograph of the same; the rapid growth appears to be pushing the sound tissue before it, rather than infiltrating it. A lantern slide showing the association of a fibroid tumor with carcinomatous degeneration of the uterine tissue was exhibited.

The causes of post-climacteric enlargement of fibroid uteri may be summarized as follows:—

- (1) Continuous growth of a soft or hard fibroid.
- (2) Development of a soft fibroid in a uterus at the time or previously affected with hard fibroids.

- (3) Cystic degeneration of a hard (?) or soft fibroid.
- (4) Sarcomatous degeneration of the same with or without cyst formation.
 - (5) Simple oedema.



Fig. 11.

Sarcomatous Degeneration of Uterine Myoma.

John Hunter's specimen, R.C.S.

An interesting account of a case coming under the second of these heads is recorded by Lawson Tait. He removed the appendages for multiple fibroids; the haemorrhage ceased entirely for two years, and the tumor nearly disappeared. After that time haemorrhage recurred, a soft oedematous fibroid was found, and it grew until it required removal. Mr. Tait was sure the soft tumor was not there at the time of the first operation.

A certain amount of activity of the circulation is necessary to remove any morbid deposit or growth. Deficient circulation may result in their shrivelling or shrinking, but not in their complete removal. This is seen in the gradual desiccation which occurs in the tissue of an extra-uterine gestation when



rig. 14. Myosarcoma of Uterus.



 $Fig. \ 13. \\$ Three of the Fibromata show dense, solid calification

past the full term. But removal does not take place. So in some hard fibroids with feeble circulation, when the tumor has long remained stationary, a deposit of lime salts, more or less considerable, takes place. This is seen quite frequently in the post-mortem room in small fibroids which have attracted no notice during life. One of the tumors exhibited showed this change in parts very well; it was in places so hard as to require the saw. Still more complete is the calcification in the next specimen, Figure 13, which had caused great discomfort to its owner. Three of the masses had become dense, solid blocks.



Fig. 15.

Large Cystic Myoma, showing enlarged Fallopian tube stretched across; lower nodule and transverse colon across upper.

Figure 15 is introduced as an example of the extreme size to which cystic fibroids may attain. The tumor caused death by asphyxia and convulsions; it weighed 27 pounds after losing many pounds of fluid contents.

Mucoid Degeneration.

Mucoid or myxomatous changes are said to be common, especially in large tumors. It seems not improbable that in some of these cases the jelly-like material seen to form the cyst wall is of a sarcomatous nature, as was the case in Dr. Burford's specimen already mentioned. One frequent cause of cysts is mucoid degeneration.

The actual conversion of the tissue substance is preceded by oedema of the connective tissue; the cells assume the characteristic spider-like form, to which the term myxoma is applied. Sections of the tissue which forms the boundary of the softened spaces in the tumor exhibit every gradation from fusiform cells to the irregularly branched cells peculiar to myxomatous tissue, embedded in a structural matrix identical in its physical character with the vitreous humor of the eye. Mucoid changes are usually accompanied by rapid increase in the size of the tumor.

Necrosis.

Another unfortunate change is gangrene, due, as a rule, to septic infection. It most commonly follows accidental wounding of the tumor (especially if cystic), e. g., by the sound. It occurs oftenest in tumors undergoing expulsion from the uterus, and may follow attempts at their removal.

Necrosis may, of course, also occur from a twisted pedicle. One example of gangrene has come under my notice. A patient introduced to me by Dr. Frank Shaw had a large abdominal tumor with acute peritonitis and high septic fever with rigors. On opening the abdomen the tumor was found to be discolored and very friable. So much so was this the case that the elastic ligature placed round it to facilitate its removal cut quite through the pedicle, and the tumor came away without any bleeding. Unfortunately the specimen was thrown away before a microscopic examination had been made. The patient died. Of partial gangrene and sepsis after operation (sometimes fatal) I saw several instances in my student days. This is happily rare now since the days of aseptic surgery and since the plan of enuccleation has been largely abandoned.

The first thing necessary in the management of fibroids is that both patient and doctor should realize that treatment is necessary, and that the patient should not be relegated to the chance benefits of a distant menopause to cure her "hardening of the womb."

On the circumstances of the individual case, and of the patient, too (financially I mean), depend the measures necessary.

If the woman has a fibroid at 25, it is safe to predict that it will be bigger at 35 and still larger at 45. If it induces excessive bleeding at 35, the probability is that it will do so at 45 or 50.

If the symptoms are not urgent, palliative treatment and watching are first required. The amount of haemorrhage first and the rate of growth next must be our guide as to what is urgent and what is not.

For the haemorrhage a variety of remedies have been suggested. I will not enumerate these from the text-books, but give you the results of my own experience. If there is much evidence of endometritis in the shape of intermenstrual leucorrhoea, the German preparation of hydrastinin (hydrastinin, Merck, introduced into this country by Dr. Burford), in the 2x dilution, 2 to 5 grains every two to four hours, will usually prove of real benfit, materially lessening the bleeding and the leucorrhoea.

Secale is a remedy which may be given either homoeopathically or antipathically. If the haemorrhage is dark, clotted, profuse, intermittent, and accompanied by expulsive pains, the third decimal dilution will usually act well, relieving both haemorrhage and pain. If the haemorrhage is excessive, but not typical of ergot poisoning, material doses frequently repeated are advisable and reliable—at least as much so as any drug.

In the case of a woman near the menopause, or, still more, if past the climacteric age, secale, tinct., steadily, with extra doses at the period if required; nepenthe or bromide in sedative doses, rest in bed throughout the whole period, occasionally saline aperients, frequently repeated hot douches (110-120 degrees F.), together with absence of sexual excitement, will

not seldom tide a patient over a difficult year or two until the benign influence of the menopause makes itself felt.

I have found better results from trillium in younger women than in those near the menopause. In doses of the 1x strength, two drops every hour during the period, it often produces a good result.

My sheet anchor, for a regular medicine given in the hope of reducing haemorrhage and size, is iodide of lime. I give the American preparation, which contains 12.5 per cent. of free iodine, about one-fifth of a grain for a dose four times a day.

I have thought that definite decrease in size has taken place in the tumors of a few patients who have been taking this preparation. Fifty years ago iodine and chloride of lime were prevalent remedies. It goes without saying that haemorrhage may be so severe as to require plugging; but if things are as bad as this it is high time more radical measures were adopted.

Is it possible to state in general terms what cases demand operative interference? Such rules are difficult to make and more difficult to follow. It is nevertheless desirable to have in one's mind some broad principles as guides, such as the following:

- (1) Ceteris paribus, the younger the patient the more likely is an operation to be both necessary and successful.
- (2) When considering individual cases, operation may be one either of expediency or necessity. Under the former class come:
- (3) Women who have to earn their living or occupy public or responsible posts. Such patients require operation when wealthy and unoccupied patients might afford to wait.

Under the heading of necessity come (a) all young women (25-25) with demonstrably growing tumors.

- (b) Cases, irrespective of age, where haemorrhage is incucing marked anaemia, and has resisted non-surgical measures.
 - (c) Cases when pain or weight are inducing malnutrition.
 - (d) Cases where impaction is threatening.
 - (e) Cases where the appendages are markedly diseased.
 - (f) Cases where the kidneys are suffering from pressure.

- (g) All cases of very large tumors in young women (25-35), that is, tumors reaching well above the umbilicus.
 - (h) All soft and cystic tumors.

It is not necessary to state before a society such as this that I do not suggest that all fibroids require operation. When all these classes have been set aside for operation, there will still remain a large number, indeed a considerable majority, which do not require operative interference. Some of these tumors are throughout practically symptomless. A few women carry large tumors to their grave, unconscious of their existence. But while this side is remembered, it should not be forgotten that, though ignored, they have a baleful effect, and may contribute toward an early demise. Indeed, I believe it is a fact that myomatous patients are a short-lived class of women.

Three main operations may be alluded to; they are:—
(1) Removal of the uterine appendages; (2) ligature of the uterine arteries; (3) hysterectomy in some form.

- (1) The first is suited for small or quite medium-sized tumors of the hard variety. Large, soft and cystic growths are unsuited for this method.
- (2) The second may be used as a substitute for the first where it is doubtful if the ovaries can be reached through pelvic impaction. It is also better suited for larger tumors than is oophorectomy. The uterus must be within easy reach by the vaginal route.
- (3) Hysterectomy is required in all the other cases needing operation.



THE MEDICAL TREATMENT OF RACHITIS, IN-CLUDING PROPHYLAXIS AND DIATETICS.

CHARLES H. COGSWELL, M.D.

Read before the American Institute of Homeopathy, June, 1898.

"Whatever tends to induce debilitated or anemic conditions of the mother, either during utero-gestation or the period of lactation, may bring the child into a state of faulty nutrition, either before or after birth, and so contribute to set up the Rachitic Slab." Professor Edmunds was perfectly correct in the above statement, as I view it, and I venture this assertion: Give me the care of the mothers and I would revolutionize the world.

In order to properly treat rachitis it is necessary to begin ante-partum. Place the mother in the most favorable sanitary conditions: pure air and pure water, with pleasant and cheerful surroundings; reasonably free from care and fatigue. She should be pleasantly employed, mentally as well as physically, with good, wholesome food, containing plenty of bone-producing elements, even though she might suffer some during labor. I believe the fad of eating freely of lemons during pregnancy to produce painless labor to be the cause of many evils: such diet not only tends to weaken the mother, but certainly the child, and may produce rachitis.

I would use for the mother during pregnancy massage, calisthenics and oil baths, to bring her system as near a state of perfection as possible. A few weeks after labor the breast milk should be examined and if not up to standard, so change the diet as to improve it; if not successful wean the baby. My first preference in the way of food for the little one, after weaning, is cow's milk, or rather, the cream from milk that has stood several hours diluted with water hot enough to melt the fat globules, and not hot enough to scald it, using five parts of water to one of cream; if this disagrees then Horlick's Malted Milk, or other foods as seems best suited to the case. When the child reaches the age of eight months, I recommend a little bouillon or mutton juice with bread; also oatmeal and cream to strengthen the physical system. This for a diet.

Following the first month I advise that night and morning

the entire clothing be changed, and in place of a bath the child be thoroughly rubbed with the hand. As soon as the muscles begin to shrink, the skin to become dry, I then use oil rather freely, externally, and continue the friction with the hand; this I hold indispensable to the successful treatment of the case, for a great amount of vitality can thus be imparted, especially if a loving mother's hand is the one employed. Bathe only semi-occasionally. An abundance of out-door air, if it be seasonable, is much to be desired. While I am not presumed to speak of the dress, I cannot refrain from mentioning the necessity of such flannel clothing as is required to protect and not burden the little one. The happy medium is most desirable. The extreme either way is detrimental.

The remedies particularly indicated are calc. carb., calc. phos., silicea, sulphur, and china; although aconite, nux vomica and chamomilla are frequently called into use.

Undoubtedly some cases are due to a psoric condition and sulphur and psorinum would be required; the latter especially when the child suffered from pains in the extremities with swelling of the feet and legs. During the precursory symptoms aconite is indicated when there is a quick, irritable pulse, with more or less heat of surface and with dry skin. Chamomilla with much restlessness or irritability, loose stool, usually green and containing more or less mucus. China when the child is suffering from exhaustion, caused by non-assimilation of food, indicated by undigested stool, loss of flesh, and coldness of the surface of the body.

The principal remedy in rachitis from which great things are expected is calcarea carb., especially when the child has prominent forehead, with large, open fontanelles and sutures, blueness of the veins, attended with tardy dentition, profuse perspiration particularly about the head and neck, inability to hold the head erect, great muscular weakness, also sour odor about its person. Calcarea phos. may be given if no improvement follows the use of calcarea carb., especially if there be much cerebral irritation, attended by a low, weak, plaintive wail. Aconite, china, and chamomilla I use in the third potency, the other remedies mentioned in the one-thousandth or higher in order to obtain the best results.

TWO HUNDRDED AND FIFTY OBSTETRICAL CASES.

BY WILLIAM E. LEONARD, A. B., M. D.

Read before the American Institute of Homeopathy, June, 1898.

Nothing extraordinary is claimed for these first cases on my record book. This paper is simply a scientific summary of work done, collated for the purpose of learning if too much or too little was done, in order that by comparisons better results may be obtained in the future, and as a text for some bits of experience.

Table showing First Labors to Succeeding Ones.

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The Sexes.

The sexes were about evenly divided in these births, the females slightly predominating.

Greatest Weight.

The greatest weight recorded was twelve (12) pounds, a stillborn child, the greatest living weight being 11½ pounds; the smallest was 2½ pounds, a little mite that did not long survive; the smallest living weight being 3 pounds. Sixty-five of these babies weighed 9 pounds and over, 33 males and 32 females. I know these weights were about right, for I took them myself on scales always carried in my bag.

Twin Labors.

There were four pairs of twins, two living, both females $(7\frac{1}{2})$ and $7\frac{1}{4}$ and $7\frac{1}{2}$ and 6 pounds, respectively), and two pairs of males, one pair at five months, living only a few hours, and the other, also males, feeble and surviving only a few days.

Terms of Gestation.

The terms of full gestation varied from 246 to 297 days, with an average in all the labors of 277 days.

Season of Confinements.

As to the season of confinements, while this number is not sufficient to generalize upon, November, October and June afforded the most cases, while February, May and July gave the least in a series of over fifteen years.

Hours of Labor.

As to the hours of labor, they were found to occur at nearly all the half-hours of the twenty-four as follows:—

12 M. to 6 A.M	85
6 A. M. to 12 N	48
12 N. to 6 P. M	47
6 P. M. to 12 M	64

In other words, without six labors in which the exact time of birth is not recorded, 149 (or about 3-5) occurred in the evening or night, and 95 (about 2-5) in the day time.

Presentations.

Vertex, O.L.A	84
Vertex, O.D.A	14
Vertex, O.D.P	I
Vertex, Face	4
Vertex, Doubtful or unrecorded	
Vertex, Brow, O.L.A. (unnatural)	2
Breech (including three twins)	10
Unknown (generally "too late")	27
-	
Total 2	54

Of these labors, 19 are recorded as "dry," 13 of them being instrumental. Peculiarities in the amniotic sac and fluid were noted twice; in one case a hydrorrhoea for 8 days before labor, the labor being normal and the child living, and the other a hasty birth before my arrival of the child enveloped in its membranes, with the placenta expelled in one strong pain.

As to the cord, in two of the twins there were two cords and one placenta. Once the cord was short (12 to 14 inches) and knotted, which I thought a syphilitic history acounted for. One attached placenta was observed, and that came away in 13 hours.

Instrumental Deliveries.

Chloroform and forceps	44	. 10 min. to 4 hours
Forceps without chloroform.		
Chloroform alone		
Ether alone		
Ether and forceps		

Total artificial labors, 95, or nearly 40 per cent. instrumental. The forceps that I use, almost without exception, are the long Flliott, the shorter (Hale's) being seldom called for. While the large blades of the Elliott sometimes mark the temples and eyebrows of the child, I prefer them for their grasping power, and find others awkward.

Injury to Perinei.

Ruptured total, 28; of these there were ruptured and immediately stitched 13, and healed by granulation 9; all these in forceps deliveries, or less than 1-3 of those deliveries.

Six ruptures occurred when the forceps were not used. None were complete, and but one was left incompletely healed, and that was because she refused to allow me to do anything more. Most of these were unavoidable, I believe, for some perineal tissues would not stretch if they were allowed hours to do so, and in the meantime the patient's strength is exhausted. I would rather stitch up a perineum than watch a six weeks' recovery. Twenty-eight ruptures out of 250 cases may be too large a proportion, but few of them were due to undue haste in delivery, as I believe. It is a favorite procedure of mine to distend the perineum beforehand by introducing the whole hand into the vagina during those vigorous late pains that are just driving the head out of the womb. If done during the pains it is not noticed by the mother, and often proves a sufficient dilatation to shorten the last stage.

Duration of Labor.

Forty-nine labors averaged II1 hours for the first stage, and nearly 2 hours for the second; while II cases, which were over 24 hours in the first stage, averaged 53 7-II in the first stage and 4 7-II hours in the second stage. The most tedious first stage was 5 days and the second I2 hours.

Craniotomy is noted once; a hospital case in which labor had already lasted 18 hours with numerous attempts at forceps

delivery, the result being a fatal septicaemia. One foetus had to be dismembered in order to bring about delivery, but with thorough emptying and cleansing of the uterus, no bad reults were had; a private case.

Puerperal fever was experienced once, largely because of bad nursing and unsanitary surroundings. These causes also contributed to the only two cases of mastitis, both of which were in tuberculous patients. Abscesses occurred in both, and each was traceable to exposure in nursing. Such results are a disgrace to the nurse, sometimes to the doctor.

Ophthalmia neonatorum is noted twice only, each time due to specific infection from a gonorrhoeal mother and uncleanliness on the part of the nurse. They were early in my practice and would be considered disgraceful now.

Two cases of cephalo-hematoma were encountered, requiring several weeks for the final absorption, one leaving for some time a bony ridge and corresponding depression in the left parietal region.

One "blue baby" was born, its feeble heart beating but 19 days.

Of the 250 mothers, five died, as follows:

- (1) Shock from hemorrhage, which had continued for hours before I was summoned; I did not attend the labor.
- (2) Puerperal peritonitis; due to late attempts at abortion with a knitting needle!
- (3 and 4) Uraemic convulsions; probably preventable if opportunity had been given me to know something of the condition of the kidneys before labor set in.
 - (5) The craniotomy case mentioned above.

Only eight stillborn children are recorded out of the 254, and 15 premature. Of the latter, one was a case of spina bifida, which lived about six weeks.

One case of placenta previa partialis is noted, the child surviving 26 days.

Two instances of puerperal mania were seen in the same patient, the first lasting for three weeks after labor; the second in the beginning of the next pregnancy very violently. The woman is now entirely well, and never shows signs of aberration.

Curiosities.

Two curiosities are noted as facts for which I find no classification. As I witnessed them myself I record them. In case No. 38 the husband stood by the bedside, and had all the regular contractive pains as the mother's uterus underwent labor, and in case No. 52, through the early months the husband, not the mother, had the "morning sickness."

Hot sterilized water is the best cleanser in the lying-in chamber, nor do I use anything but calendula where there are cut surfaces, and therefore liability of infection.

As Dr. Winterburn, formerly editor of the "Homeopathic Journal of Obstetrics, so ably insisted, it is a great advantage to the mother as well as to the physician to be engaged early for the approaching confinement, the very first month being none too early. He then has opportunity to study and anticipate constitutional tendencies, as well as to regulate diet and hygiene. Grauvogle's method of medication during early pregnancy, where scrofulous children have been the result of former pregnancies, has proven very helpful. Indeed, I can truthfully affirm that Calc. carb. and Sulphur have seemingly entirely changed the nature of the infant. The indications are the general constitutional ones for those remedies, awkwardness and clumsiness and weak knees on walking being especially applicable to Calc. carb.

Diet.

The diet is always regulated to this extent: meat is lessened, if not quite excluded, during the last six weeks, and plenty of grain food and vegetables and fruit enjoined. I do not believe in the extremity of a "rice and fruit" diet, for even with the probable result of an easy labor that plan gives too little vitality to the child. I have yet to find a vigorous child born without severe suffering on the part of the mother. On the contrary, those born without pain to the mother have, in my experience, easily succumbed to disease. Probably nature intends, as the Scriptures inform us, that the mother's travail shall not only bind the mother's love more closely to her offspring, but also give that offspring a better hold upon this life.

Institute Etchings.

"Original communications to the Bureau of Obstetrics and Gynecology, June, 1898, stenographically reported for this Journal.

ETIOLOGY OF PROLAPSUS UTERI.

DR. J. KENT SANDERS.—The only point which occurs to me in connection with the possible causes would be a floating I have a case under observation, where the only possible cause for the prolapsus was a floating kidney. The treatment included massage and postural treatment, but I think we should not have gotten as good results had we not anchored the floating kidney. I wish to emphasize the advantages of massage; massage for the pelvis as well as for the balance of the body. Many of these cases are the result of a general undertone of the muscular system, and vigorous massage is an excellent adjuvant. In the cases which are not extreme a great deal may be done with postural education, sleeping in a certain position tending to take the pressure off the pelvic organs. In one or two cases where it has occurred in connection with a general rundown condition of the system, I have found that they generally sleep on one side, with the limbs drawn up and the head high, so there was constant pressure brought on the pelvic organs. Under the care of a nurse during the night a change in the habit of sleeping position would help the case.

VENTRAL FIXATION.

DR. J. H. McCLELLAND.—As a result of considerable experience I am doing ventral fixation much more frequently than formerly. I have been led to perform this operation in preference to others, because I have generally found prolapsed ovaries in connection with the prolapsed uterus, and I believe that more suffering results from the prolapse of the ovaries than of the uterus. Whenever I find a prolapsed ovary with adhesions I do the ventral fixation; I believe I have done this twenty times in the last year. I do not know that the plan is original, but I merely fix the uterus to the peritoneum; instead

of making the suture embrace the entire abdominal wall, I fix it with a silk suture to the peritoneum alone, and in that way allow it some swing. I have examined these cases at intervals afterward, and found perfectly good results. It not only holds the uterus in position, but supports the prolapsed ovaries.

MARTIN'S OPERATION.

DR. GEORGE F. SHEARS.—The device is the invention of Dr. Franklin Martin, of Chicago, and I have had the pleasure of seeing him perform the operation. He uses for sutures the pyoktannin catgut referred to the other day; it is prepared in formalin, and then boiled in pyoktannin, and makes a good suture. The No. 5 size is said to last two weeks, but he uses No. 3 in operating for suspension of the uterus. He uses a strip of peritoneum or the remains of the urachus. In view of the great fear of catgut which has been expressed, it is interesting to note what good results he has had with this suture, even when used in several layers, where there is much danger of infection. It would show, at least, that, with proper preparation, there should not be so much fear of catgut, and there is no suture material so good.

UTERINE DISPLACEMENTS.

DR. E. S. BAILEY.—The question of uterine displacements is one which very frequently comes up, and, from the surgical standpoint, the uterus is almost always the offending organ. We hear this so often, "First the uterus was attacked, then the surrounding organs were looked after." It is not sufficient merely to replace the uterus; it must be held there, and in so thorough a manner that it will stay until the new arrangement is so complete that it cannot get away out of position and into another pathological position. It is a cure for what is called an incurable disease. As. Dr. Shears has said, there has been a widespread distrust of catgut, but there is now a tendency to try it again, because it is the ideal suture material. Carefully approximate the tissues intended to heal, readjust the organs which are out of place, and make the tissue itself the only support.

PROPHYLACTIC TREATMENT OF PROCIDENTIA.

Dr. J. J. THOMPSON.—It seems to me that not enough stress has been laid upon the prophylactic treatment of procidentia. I believe that in every case we have one or two conditions—an abnormally heavy uterus, or an abnormally weak support, or both. If the conditions were immediately corrected, we should almost never see a case of procidentia. If the uterus does not return to normal condition after labor, it is a heavy, dragging weight, pulling itself down, and the other pelvic organs with it. If it is from a submucous laceration, it should have been repaired at once, and there would have been no prolapsus. But many cases come to us so long after the original injury that the parts have lost their tonicity, and a plastic operation is necessary. In every case of labor the physician should carefully examine the parts at once, and if there is injury, whether actual or submucous laceration, it should be made good as soon as possible. I do not believe there is much necessity for the Alexander operation; I have never seen a case where I deemed it necessary, and I have seen so many poor results of the operation at the hands of others that I have become discouraged. I have not heard one word said about the medical treatment of these cases; yet we all know that after any surgical treatment there remains a condition which nothing but the indicated remedy will overcome. beginning of these conditions oftentimes the remedy will do the most good.

TREATMENT OF PROLAPSUS.

DR. R. LUDLAM.—I do not desire to make a point against therapeutics, but to add additional resources from our additional experience. We are getting enough specialists, men of capacity, to stand up and do us honor wherever they go. When you reflect that a woman with a slight degree of prolapsus does not consider herself ill, and goes on for years before applying to a physician, you will realize that complications have arisen in the meanwhile, and that no one kind of treatment will suffice for all cases. A great variety of resources are required, and they have been developed by the modern gynecologist until they are innumerable. Too much has been

claimed for some of them, and some have been proven failures. We need many resources, and the thing to do is to apply the right remedy, be it medical or surgical. The physician should select the proper treatment and apply, and not be tied to single fads or operations. There will be justification for second operations, for no one operation will suit all cases. If you apply hysterorrhaphy indiscriminately, you will make a mistake. It is thirty years since the operation was first done, and the operator took the ovary and removed it, and then made a hysterorrhaphy. If there is any enlargement of an ovary it should be taken out before the hysterorrhaphy is made. As to the Martin operation, it seems to me that the women will not run very much after that kind of a ribbon. There are conditions and complications; do not depend too much upon any one procedure. Cases become chronic before we see them, and no one operation is adapted to all. An operation done, and intelligently done, even if done over again, is better than hunting around for an orifice which may be dilated.

ETIOLOGY OF PROLAPSUS.

DR. J. C. WOOD.—As to the etiology of prolapsus, it is a fact that all such cases must be preceded by a retro-displacement; it is impossible to have complete procidentia without having a retro-displacement. There may have been pressure upon the anterior surface. This brings up a practical point in relation to ventral fixation; if we make simply a peritoneal attachment, there may follow such a stretching of the tissue that the condition will become as bad as before the operation. To make the operation successful, the stitch should be passed through the posterior surface of the uterus, so as to tip it forward. I had occasion to remove a suspended uterus, and found its attachment had stretched until it was six inches in length. It was not a proper case for fixation anyway, as there were several small fibroids of the uterus. Fixation should be limited largely to those cases where the appendages are so diseased as to warrant removal at the same time. Where the ovaries are left behind, there is apt to be trouble in subsequent pregnancies. I opened an abdomen several weeks ago where the uterus had been suspended by the round ligaments and

one ovary left behind, which I had to remove. The uterus I found beautifully suspended by the round ligaments and in excellent position. In case of hysterectomy take care not to injure the ureters which are displaced with the bladder and uterus. My plan is to work close to the uterus, amputate the ligaments high up, and, bringing them up into the vaginal wound, fix them there.

ETIOLOGY OF DISPLACEMENTS.

Dr. WILLIAM A. FORSTER.—As a causative factor of displacement we have nervous trouble—neurasthenia. If of nervous origin, why not go to the root of the trouble, treat the nervous system, and cure displacements in that way? If we have other causes, such as traumatism, parturition or fibroid growths, let us treat them. But among causative factors we so often find none of the foregoing, but others which we may overcome by the homoeopathic remedies. There are two classes of physicians; one which can cure everything with the remedies, and which considers nothing as surgical. and another which cures everything with the knife alone. Some homeopaths do not care anything for the name of the disease, if they only have the symptoms; they say they do not name their babies until they are born. As good surgeons and physicians we should search deeply, study pathology, learn diagnosis and know what we are about. Prescribe on symptoms alone, and you will prescribe for the knee in hip-joint diseases: prescribe for cancer of the stomach where there is a ventral hernia. I have had a good deal of experience in uterine displacements, and we find one causative factor in the high school system. I have been for some years the physician to an educational institution, averaging an attendance of fifty young women busy with their studies. You would be surprised to know how many of them miss their menses for months at a time, owing to the development of the mental at the expense of the physical. We should change their vocations, give them outdoor exercise, change of diet and stop their running up and down stairs. They run up to the top story when they ought to be out of school; they should not be allowed to take such exercise at puberty. As to the examination of

immature girls, it always makes me feel bad to have to examine a young girl, and I make it a rule to do so by external manipulation or through the rectum, rather than rupture the hymen. This indiscriminate examination of growing girls is a crime. We find some physicians examining every woman who comesinto the office, taking a great big speculum and giving local treatments two, three or four times a week. Don't make indiscriminate examinations of young girls. Many other conditions. may simulate retro-displacement; maybe a posterior fibroid may simulate retroflexion. The sound is a dangerous weapon unless the uterus be thoroughly dilated first. Often these conditions are due to a relaxation of the muscular system, and massage, electricity and the homoeopathic remedy will do much excellent work. I abominate pessaries and props; give the patient exercise and Delsarte, and let her develop herself. In ventral fixation I always scarify the uterus and stitch it thoroughly to the abdominal wall down opposite the round ligament, in order that it may develop, in case of subsequent pregnancy. The peritoneum is unstable, so stitch clear through the muscular tissue. Always use an absorbable suture, or one you can afterward remove. I have had the pleasure of attending three of these cases in subsequent confinements, and in no case have I seen a return of the old trouble. I operated upon a lady for appendicitis, for whom I had performed a ventral fixation two years before, and found a good, strong ligament; since then she has had no return of the former headaches, backaches, etc.

OPERATION FOR RETROVERSION.

DR. H. F. BIGGAR.—At the present time there are forty-five different surgical operations for the restoration of the backward displaced uterus, but we have not yet the perfect operation. What will answer for one case will not answer for another, so we must be careful in making the selection. I believe the round ligament operation is the best, but at the uterine end, not at the symphysis pubis. Go in between the bladder and uterus, pull the uterus out and loop the round ligament; if necessary, loosen the attachments and sew it somewhere else to hold the uterus in place. I believe this operation:

will give better results with less risk. All the ligaments must be taken into consideration in this matter; you will find abnormal conditions here which must be corrected. As to the Alexander operation, you will frequently find, on opening the abdomen, a loose and relaxed condition of the round ligament, and if you strain it it is apt to break again. But if you will go in and sever its attachment and attach it to some other place, you will have a guy which is strong enough to do the work. This operation is now on trial, but we have not had sufficient time to judge as to permanent results. There is an objection to ventral fixation, owing to the liability of interference with the intestines, also with suspension. Fixation should not be performed if there is any liability to maternity.

UTERINE DISEASES.

DR. L. L. DANFORTH.—No rightminded physician would ever examine a young girl unless there is good and sufficient reason for so doing, and, if such reason exists, the examination should be made without hesitation. I must say I have been astonished at the number of young women presenting unmistakable evidences of uterine diseases and diseases which nothing but local treatment will remove. Remedies will remove many of the symptoms which we are accustomed to prescribe for, but the disease which causes these symptoms persists until the health of the patient is undermined. As rightminded physicians, broad and appreciative of the serious nature of the proposed examination, we should not hesitate to make such examination in the proper way, at the proper times and under the proper conditions. I hesitate many times. and can sometimes make better diagnosis per rectum than by way of the vagina. If we approach the patient in the proper manner we may make the examination without shock and with but little pain. An instance occurs to me. A young lady was sent to me for consultation suffering with uterine and ovarian disease. I found the uterus on the floor of the pelvis, congested, with the ovaries tender, congested and displaced. How foolish to have simply made a prescription. The condition was so serious that I even advised operation. She went back to Brooklyn, but finally returned to me, and I have had her

under treatment for eighteen months. By the use of electricity I have entirely removed the sensitiveness of the replaced uterus, and retain it by a well-fitting pessary. With the internal remedy I have removed symptom after symptom. I see many of these cases with displacements and congested ovaries, and I never hesitate to treat them in the proper way. Pessaries have been tabooed, but they are hard to get along without. We know the value of the Alexander operation and of ventral fixation; the patient gets the very best of results, and the pessary is not necessary. The ordinary and well-tried means of treatment should not be set aside simply because the patient is young and inexperienced; we should do all we can for her.

AUTQ-INTOXICATION.

DR. C. T. HOOD.—I think that not enough stress has been laid on the matter of the care of the bowels in these cases. Before a young woman should be made the subject of surgical work, every organ of the body should be put in good condition. In many cases these symptoms are the result of autointoxication. By seeing that the bowels are acting freely, and by clearing out the material which has laid for many months, we shall relieve many uterine symptoms without surgical interference. In the after treatment of the plastic cases great care should be given to the bowels. Both the writer of the paper and some of the speakers have referred to the use of electricity in these conditions; too much cannot be said as to the careful, painstaking and thorough application in these cases. electrode should ever go into the uterus without being thoroughly disinfected; carelessness here means sepsis. Many brilliant operations for curettement have been spoiled by the carelessness of the operator in using a dirty electrode and setting up the same condition he was trying to get rid of. Many physicians will use the faradic current in the uterus where there is a cystic condition of the ovary or a condition of salpingitis. That is the very worst thing you can do; it is not to be used in acute inflammatory conditions. As to the use of the positive pole in the vagina, if I used it there at all I should protect it: I never use a sponge electrode there at all.

ECTOPIC GESTATION.

DR. J. C. FAHNESTOCK.—In reference to diagnosis before rupture there are many things to be thought of. It brings forcibly to mind a case I had in '93. One of my patients had pain and collapse, with indications of haemorrhage; I gave her what I considered the indicated remedy, and she grew better and was about for some time. There was a small growth on the right side, and any one would have called it an ectopic gestation. She went to the World's Fair, and had another attack; abdomen greatly distended, cold perspiration, with all the symptoms of collapse. I advised laparotomy, which was agreed to, and to my surprise I found a small uterine fibroid, with the pedicle twisted upon itself, producing all these symptoms. This suggests a query how to differentiate between appendicitis and ectopic gestation. In appendicitis they will go along, apparently well, with or without some menstrual irregularity, and suddenly collapse. We find the conditions also where an old peritonitis interferes with intestinal action, leading to collapse. I believe that many cases diagnosed as ectopic gestation turn out to be something else.

DIAGNOSIS OF ECTOPIC GESTATION.

DR. WILLIAM A. FORSTER.—As to the diagnosis of ectopic gestation, it depends upon each individual case. the case of a lady of large size it would be a difficult matter, but if of small build it would be decidedly easier. One point to be considered is the rapid growth of the tumor: then you have all the symptoms of pregnancy, and almost always the expulsion of the decidua, that you do not have in appendicitis. There are the ordinary symptoms of pregnancy. In a person not too fat you can almost outline the appendix. Take a fibroid and it will feel different; it's harder, more elastic, and does not grow as rapidly. You may have another thing to confuse you, as an ovarian cyst, but it has not the throbbing or the expansive pain. The ovarian cyst would fluctuate; the uterus would be patulous in gestation and not in appendicitis. Four weeks ago yesterday I operated upon a case of double ectopic gestation—of both ovaries. I operated something over a year ago on a case; they had no comforts or proper arrangements for the mother, and she died, but the child still lives, and was past full term. Then there is the history of sterility for some time with ovarian and tubal disease. There is some disease of the lining of the tube which prevents the descent of the ovum. I should not rely upon electricity, but would cut down in a moment if there was a chance for the woman. I do not believe there is much difference between the action of the positive and that of the negative pole in these cases; either will do the work.

DIAGNOSIS BEFORE RUPTURE.

DR. L. L. DANFORTH.—I believe that an accurate diagnosis before rupture is one of the most difficult problems before the physician; it is easy on paper, but hard at the bedside. Tait says it cannot be done before rupture. The other day a physician in New York sent for me to see a patient, concerning whom he had a beautiful history of ectopic gestation, sterility for some years, missed one period, flowed irregularly, passed some shreds, milk in the breast, etc., etc. I fell into the trap, although I know the diagnosis is difficult, and, many say, impossible. I had the diagnosis made in my mind before I ever saw her. I did not mean to be trapped, but found the uterus large, and on the right side what was thought to be an extrauterine cyst and something else alongside. Three of us found it, and advised operation. We opened the abdomen and found a foetus, but it was in the uterus. She got well beautifully. A man should be very careful about his diagnosis before rupture; in the case mentioned we should have made the examination under an anaesthetic. These cases of tubal gestation never go beyond the twelfth week; something happens before the third month. If you expect a tubal gestation watch it about this time.

FIFCTRICAL DIAGNOSIS.

DR. J. J. THOMPSON.—I do not want to say that electricity is never advisable, but I do believe that in a majority of these cases we can make a correct diagnosis in a simple manner, and early in the case, by going into the peritoneal cavity through the vagina. In several cases where in doubt I have invaded the peritoneal cavity through the cul-de-sac, hugging the uterus

very closely, and have thus been able to remove cystic tubes; only recently in this manner I removed a pus tube and ovary as large as a hen's egg. Two weeks after leaving the hospital the patient resumed her work as a floor lady. In nine out of ten cases where there is much uncertainty, we may find out in this way, and with little danger. If you find it necessary, there is nothing to prevent completing the laparotomy through the abdominal route. Clamps and ligatures may be as easily applied in these cases as in cases of vaginal hysterectomy.

DIAGNOSIS UNDER ANESTHETICS.

DR. C. B. KINYON.—As to the electricity. I have never used it, but operated upon a case where it was used, and it did the work. One of the best men of the country—Thomas, of New York—advocates it. While a diagnosis is not made in ninety-nine out of a hundred cases, I do believe it may be correctly made in the majority of cases, if the patient will come to us in time. But I never make a positive diagnosis of things in the pelvis without an examination under anaesthetics. If you will mix one drachm of nitrite of amyl with a pound of chloroform, you will see how much quicker and safer it will do its work. As for the diagnosis, you have in every case the history of the patient, the pregnancy symptoms present, subjective and objective; you have the throbbing pulsations and the rapid growth. I should be afraid to tackle the gestative sac through the vagina; I should prefer the abdominal method when in doubt. I have diagnosed ectopic gestation in three cases before operation. The pregnancy in one case was less than one month.

ENGAGEMENT OF THE HEAD.

DR. B. H. OGDEN.—One of the reasons why we fail to get an engagement of the head is because the uterus is not expending its force along the line of the superior strait, and for this difficulty I have used the postural treatment. Sometimes the patient lies flat, and the uterus is pushing against the symphysis pubis; in such case elevate the body and alter the action, so as to make the force come in a direct line; or, the trouble may be the reverse, and the uterus may be occupying

a lateral position. It seems to me a very important thing. Also as to the pelvimeter, we are learning to use it, and know what we have to do before we have to do it. We learn beforehand that an operation is to be done, and we are able to get the patient ready for it, and in this way we shall save many lives, both of mothers and children. I favor version in case the head does not engage.

CHLOROFORM ANESTHESIA.

DR. F. J. BOUTON.—I should like to refer to the use of chloroform in the first stage. I have frequently found when the head is pressing the anterior lip of the uterus down, the os is so far up behind that you can scarcely reach it; consequently the pressure does not produce any dilatation. Frequently the os will be so sensitive that you can scarcely touch it, and if you try to pull it down they will fairly scream. Give a little chloroform to deaden the sensibility, and you can pull the uterus down and dilate. Sometimes the head will rest upon the pubic bone; they will not endure the pain of pressing it back, so give them a little chloroform for a few minutes until you can press the head back. I have not used any chloral on account of the horrible taste.

EPISEOTOMY.

DR. T. G. COMSTOCK.—As to the cutting of the vagina -episeotomy. It is many years old, but England seems to have forgotten it. The vaginal opening is cut one-half or threequarters of an inch with a guarded bistoury, and it will relieve the passage of the head very materially. It has been called the "young doctor's operation," but it ought to be called the "old practitioner's operation." As to chloral, homoeopaths do not like to use it. It is an excellent remedy, but treacherous; it killed Louis Napoleon when he was really recovering. It is an excellent analgesic, and I have never had any trouble from its use. In many cases of after-pains it will relieve like a charm. In lingering labor a dose of chloral will frequently rest the woman. I never give chloroform in the first stage of labor if I can help it. I remember being called in consultation in a labor case and took my forceps. The doctor told me the pains had stopped, so he had given her a good dose of quinine. He

said the waters had broken, but there was paralysis of the uterus. I examined the woman, and found the bag of waters unbroken, so I ruptured it; the waters flowed away, the pains came on, and I left the woman in the hands of her doctor. There may be a paralytic condition here, and the mere rupture of the water sac will bring on the pains. Never give chloral hydrate where there is organic heart disease.

A REPLY TO DR. FAHNESTOCK'S CRITICISM.

BY ELIAS C. PRICE, M.D.

Criticisms are often an advantage both to the critic and to the party criticised, as it sometimes brings out for investigation that which otherwise would not be thought of.

I am glad to know that Dr. Fahnestock has had four cases of conception to follow cases of thorough curetting. I have heard two other physicians make the assertion, in a general way, that they have had cases of conception after curetting.

If my critic was a medical man in 1864, when Dr. E. M. Hale published his work on "New Remedies," he will remember perhaps, that Dr. Hale made the assertion that if the remedies that the allopathic physicians were in the habit of using for certain symptoms, with any degree of certainty, were submitted to an exhaustive proving by an experienced homoeopath, they would be found to be in reality homoeopathic remedies for those symptoms, and where they have been submitted to the above test I have found Dr. Hale's assertion to be true; therefore, if clinical experience, verified over and over again with the old remedies, holds good, why should not frequently-verified clinical experience with the new remedies justify a man in sometimes using them for symptoms for which we have no proven remedies?

Dr. Fahnestock next attacks me for using vinegar to contract the uterus after delivery.

I want my friend to know that I have practised medicine

*My original article was published in the November, 1897, number of The Homeopathic Journal of Obstetrics.

for over half a century; for many years I did not use anything until it was indicated, and I came very near paying very dearly for it many times, and my own beloved wife came very near becoming one of the victims. I at length came to the conclusion that an ounce of prevention was worth a great many pounds of cure.

Listen, my friend, to what Egbert H. Grandin, M. D., the translator of Dr. A. Charpentier's "Cyclopaedia of Obstetrics Gynecology," says, Vol. I., page 459:—

"The practice of administering ergot immediately after the delivery of the placenta, as a routine measure, we believe to be a wise one. Not only does ergot tend to keep up firm and equable contraction, but by so doing it also assists the process of involution. In no given case can the accoucheur feel that the uterus will not relax, and we may effectually guard against this by giving from one to two drachms of the fluid extract of ergot before we leave the patient. When the stomach is irritable, the drug may be given by rectal suppository as the aqueous extract (five to ten grains). Further still, we believe it is good practice to continue the ergot for ten days after delivery, giving fifteen to thirty drops three times a day. The object of this is to assist involution. If the drug seems to cause after-pains, these pains are salutary usually, since that they may mean that the uterus is endeavoring to expel clots. These pains are rapidly expelled by chloral hydrate (fifteen grains by mouth or thirty grains by rectum). Editor."

I do not quote this in commendation of his treatment, for the dosage is too large; 20 to 30 drops would be sufficient; but I quote it to emphasize his prognosis. A continuous tonic state of contraction of the uterus after delivery is not the normal state of that organ.

What is it that produces after-pains? It is the alternate contraction and relaxation of the uterus, which occurs every ten or fifteen minutes. During the period of relaxation blood often accumulates in the uterus, and perhaps owing to an unequal contractility of the muscles of the uterus (too little contraction of the fundus and too much contraction of the cervix), the blood accumulates during every period of relaxation, until the uterine sinuses are dilated, a gush of blood takes

place, and your patient is in a state of syncope, if nothing worse.

We must use our common sense, and not trust to the Lord to do everything for us. Why did He make no valves in the veins of the rectum?

Why did He make the appendix vermiformis? If we trust to the Lord to prevent post-partum haemorrhage, why not trust Him to cure haemorrhoids?

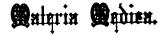
Large doses of ergot sometimes aggravate the after-pains. The way to cure after-pains is to give something that will produce a continued tonic contraction of the uterus, and you get rid of the after-pains, you get rid of the accumulation of blood clots in the uterus, you get rid of what the old authors used to call milk fever, which is a mild attack of septicaemia. For several years I gave my patients about three drops of ergot every half-hour to two hours for after-pains. Now I put a tablespoonful of vinegar in half a glass of water, and give a teaspoonful every half-hour to two hours.

I have had many cases in which manipulation of the uterus would produce temporary contraction, but it would not last; relaxation and haemorrhage would occur again and again. Give a teaspoonful of vinegar in a fourth of a glass of water, put one hand on the uterus while she swallows it, and you will feel the uterus contract in half a minute, and you can go home with an easy conscience and go to sleep.

Book Reviews.

Diseases of Women. A Treatise on the Principles and Practice of Gynecology. For Students and Practitioners. By E. C. Dudley, A.M., M.D., Professor of Gynecology, Northwestern University Medical School; Gynecologist to St. Luke's Hospital, Chicago; etc., etc. Lea Brothers & Co., Philadelphia and New York, 1898.

This is a practical treatise on gynecology, including the most appropriate precepts in principles and practice, and excluding whatever is not found in pathology or carefully observed experience. The arrangement of the book differs from the usual method by the division of the work, on pathological lines, into five parts: General Principles; Inflammations; Tumors, Malformations and Tubal Pregnancies; Traumatisms; Displacements and Pelvic Massage; thus preserving the sequence of each pathological process. For the student this work is particularly well adapted; it is clearly and interestingly written, and has been boiled down to eliminate all unnecessary matter, and the arrangement is such as to keep the evolution and progress of each pathological condition in line, and the etiological sequence has also been observed. A special feature is the space devoted to Pelvic Massage according to the Brandt method, in which the various manipulations are shown in nineteen illustrations, and this therapeutic measure is fully described.



Cimicifuga in Chorea.

When the choreic movements are more on the left side and are complicated with myalgia and rheumatism.

Helonias in Leucorrhea.

Dr. Ward: Helonias is recommended by Hughes in women affected with prolapse, mucous or watery leucorrhoea, with general weakness. Mother tincture or lower dilutions.

Helleborus in Albuminuria of Pregnancy.

This remedy is useful where there is catarrh of the bladder and kidneys; the urine is scanty and dark, accompanied with bladder weakness. Helleborus is particularly appropriate if there are meningeal symptoms.

Relladonna in Infantile Diarrhea.

Dr. Ealer: Sudden onset, high fever, flushed face, hot head, drowsiness but unable to sleep, with jumping and starting and rolling of the head, nausea or vomiting. Thirsty. Character of stools may be of any kind, but if seen early usually undigested; stools greenish, watery with whitish lumps.

Naphthaline in Pertussis.

Paroxysms of extreme length. A sense of constriction about the chest preventing inhalation, or as if the patient could not complete expiration. Great dvspnoea, relieved by violent motion. Feels better in the open air. Great soreness of chest and abdomen, must loose the clothing.

Spongia in Membranous Croup.

Spongia has the most remarkable applicability to that terrible acute disease—membranous croup—provided, however, the local inflammation has first been diminished or subdued by a very small dose of aconite. The additional use of a small dose of hepar sulph. will rarely be found necessary.

Trillium in Uterine Hemorrhage.

Habitual hemorrhage, blood dark and clotted, with sensation as if the thighs would separate. Amelioration from a bandage about the body. Flow active or passive, appropriate at the menopause. Hemorrhage caused by fibroids, or after a violent exertion. Sometimes prevents abortion.

Borax in Constipation.

Dr. Talbot: Child of seventeen months had had no movements of bowels for "months and months," without the aid of enemas. Pathogenic symptoms: Aphthous patches covered portions of the hard palate. Clinical symptoms: In the earlier history the child had shown great dread of downward motion. Had weaned itself. Constant crying, but no tears. Remarks: Condition entirely relieved within twelve hours.

Chloral hydrate in Obstetrics.

Dr. C. B. Kenyon: I would like to give my experience with the use of chloral. I always go to a case of confinement with a bottle of chloral hydrate, simple syrup and distilled water. It is a good diuretic, controls pain, and will do more to cure albuminuria than all the materia medica put together. I have had cases where the amount in the tube would appall you, the patient with convulsions and puerperal insanity, and I have never seen a case it would not cure. I give a teaspoonful every fifteen minutes in case of pain until the patient is quiet or I have given six or seven doses. In pregnancy a teaspoonful every two hours makes eight grains every two hours. I recollect one case of convulsions where I wanted to give chloroform

and deliver, but the other doctor said give chloral; he said it would dilate the rigid os, and it did. I am never without this mixture."

Nux vomica in Threatened Abortion.

Dr. Danforth: Threatened abortion due to varicosed condition of uterus, brought about by frequently recurring congestions; uterus in a relaxed condition. Threatened abortion, or retained placenta, after abortion or parturition, with a constant feeling of uneasiness in rectum, as though bowels ought to be moved. Profuse hemorrhage after abortion at three months; flow aggravated at 3 a. m.

Belladonna in Sterility.

Dr. Jones (Columb. Med. Jour.) states that belladonna is followed by more or less benefit in every disease to which the female sexual organs are liable; and in married women who, though apparently enjoying the best of health and never suffering from any irregularity of the sexual organs, are yet sterile, the exhibition of belladonna internally for some weeks is so frequently followed by pregnancy as to preclude considering the occurrence as a mere coincidence. Though advancing no theory in regard to the matter, the author has noticed that during the exhibition of the drug the external genitals become more relaxed, and the os and the cervix more pliable and softened.

Senecio aurens in Menstrual Disorders.

This drug will be found indicated in the irregularities of menstruation in young girls when the flow is suppressed by moist cold, especially by getting the feet wet, in menorrhagia when the haemorrhage is copious and persists for a long time, so as to bring about anaemia. It is useful in girls who tend toward chest affections, with the menses suppressed for several months, and who become pallid, weak, and complain of a dry cough and expectorate blood. The drug will re-establish the menstrual flow and cure the cough in a short time. Haemorrhages from all the mucous membranes; coryza with epitaxis, bloody expectoration, naemoptoe, catarrhs of all the mucosa, with a haemorrhagic tendency and congestion of the kidneys, with haemorrhages. In chlorotic girls with uterine, renal or vesical haemorrhages, senecio renders great service.

Phosphorus in Measles.

Violent and exhausting cough; dry cough, with desire to vomit or vomiting; typhoid symptoms, with loss of consciousness; watery diarrhoea; tongue coated with dirty, thick mucus; black lips; debility; complication, with bronchitis.

Mercurius vivus in Scarlet Fever.

Dr. C. L. McElwee: Ulcers in mouth and throat-band upon tonsils, covered with grayish sloughs; swallowing difficult, attended by stinging pains (apis); profuse, stringy and very offensive saliva; acrid discharge from nose (arum, nitric acid); profuse perspiration; restlessness. Glandular swellings about the throat, and possibly involvement of the ears—children of rachitic tendency.

Veratrum viride in Scarlatina.

Dr. Dewey (Med. Cent.): Veratrum viride succeeds to the place made vacant by the subsidence of the more acute symptoms of aconite. Its pulse does not have the sharply defined stroke of the latter remedy; it is rather compressible under the fingers ,and is full and flowing. The skin is more moist than under gelsemium, and may be quite mottled. Cases calling for this remedy are not characterized by the throat indications belonging to belladonna.

Kreostum in Diseases of Women.

Dr. Searle: Inflammations of the female sexual organs characterized by erosions and offensive excoriating discharges. Erosion of cervix, with burning deep in vagina, great heat and soreness of the mucous membrane, bearing-down pains and offensive acrid leucorrhoea. It is valuable as a palliative in scirrhus of the uterus and epithelioma of the pudenda, with the burning pains as from hot coals and offensive discharge. Leucorrhoea of the peculiar odor of green corn. Pruritus of vulva with offensive moisture.

Senecio in Puerperal Mania.

Dr. Talcott (Jour. Belge d'Hom.) reports a case of puerperal mania as cured with senecio aureus, where, after the suppression of the lochia, a puerperal mania developed which resisted the usual remedies, acon., bapt., bell., hyos., puls. and stram., and greatly improved under senecio 3x, a drop every two hours. At the same time the flow reappeared. A relapse occurring,

bell. was administered, to be followed by sen., which led to a prompt and lasting cure. Senecio is very highly recommended by allopathic writers in renal haemorrhages. The eclectics consider it to be an emmenagogue, and administer it not only to stimulate the function, but also when in excess or otherwise deranged.

Mercurius in Leucorrhea.

Dr. T. F. Allen: Leucorrhoea worse in the evening, greenish, causes biting forepart of genitals, worse evening and night, stretching forward by burning.

Merc. bin. jod. in Diphtheria.

Dr. Middleton: I believe to get the best result from this drug in diphtheria it is often necessary, where indicated, to give it in large doses. I use the 2x trit., and often find it necessary to use as much as 5-grain doses, frequently repeated.

Mercurius vivus in Diarrhea of Children.

Dr. Gaston: Mercurius vivus has green and mucous stool, also shiny, frothy or bloody. Ineffectual urging to stool every moment, with tenesmus in rectum. Great pain before stool, weakness after stool.

Gossypium in Ovaritis.

Dr. McMichael (Hahn): Stinging, burning pain in left ovary, which comes and goes with swelling, pain extends down left limb before, during and after menses; cannot lie on back, it feels as if broken; has to lie mostly on stomach; nausea in morning before breakfast; anxiety and sighing; the pains are wandering, jumping from one place to another; scanty menses. lodine in Croup.

Dr. Middleton: This medicine will cure more cases of laryngitis and croup than any other one drug, used in 1x dilution at short intervals when case is severe. Indications: Screness, hoarseness, dry barking, crowing cough, difficulty of breathing and scanty or no expectoration. It seems to act as well in children of either temperament or complexion.

Continuous Pressure in Chronic Pelvic Inflammation.

In the middle chronic stage of inflammation without fever I have employed iodine, ichthyol, brine baths, douches, massage, etc., and lately have tried continuous pressure for several hours a day on the pelvic organs by means of a shot-bag. The

shot-bag is prepared in the following manner: a very strong rubber condom is drawn over a cylindrical speculum, which is introduced into the vagina with the pelvis elevated, and filled with No. 3 shot. After stroking up the iliac flexures, another rubber bag filled with shot and weighing several pounds is applied to the iliac regions. After a few hours' use, the shot-bag in the vagina adapted itself completely to the contour of the vagina. The vagina is lengthened and considerably dilated. All the pelvic organs are elevated: the lower portion of the abdomen is deeply depressed for some time after removing the external weight, and palpation of the finest details of the pelvis is greatly facilitated. Excellent success has been obtained by this method in the treatment of chronic perimetritis, parametritis, swelling of the adnexa in partly adherent retroflexions of the uterus, in cicatricial and in infantile contraction of the vagina.

Pądintrigs.

Scarlatina and Measles.

Dr. Lindsay (Med. Age): To discriminate between scarlatina and German measles is hard upon the following points: In scarlatina there is initial vomiting; a brief but well-marked prodromal stage, with vomiting, chills, headache and sore throat, sometimes going on to ulceration; no early enlargement of the post-cervical glands. In German measles there is no vomiting, no prodromal stage, the rash being often the first symptom. and always appearing on the face; little or no constitutional symptoms; no ulceration of the throat; a very characteristic early enlargement of the post-cervical glands.

Etiology of Chorea.

From statistics it would appear that the disease occurs in those of neurotic heredity, who have recently suffered from injection of some kind. This infection is, in the majority of cases, rheumatism, but there are many instances of chorea arising from other conditions, more particularly various specific diseases, such as measles (with or without broncho-pneumonia), scarlet fever, typhoid, influenza, bronchitis, tuberculosis and

varicella. Even boils with marked glandular enlargement, impetiginous eruptions on the head and suppurative otitis seem to be capable of producing chorea.

Clinical Forms of Pulmonary Tuberculosis in Children.

Prof. Comby (La Semaine Medicale): Tuberculosis is exceptional before the third month of life, which speaks against direct heredity; and, indeed, the frequency increases from the first months of life, the minimum, to the second year, the maximum. This fact would seem a powerful argument for contagion. The child, creeping about the floor, breathes in the infectious dust, which localizes itself in the tracheo-bronchial tubes, thence to invade the lungs or other organs after a longer or shorter incubation. One may affirm that children become infected, not through the digestive tract, but through the respiratory passages. Among twenty-four little patients who were carefully followed up, the following clinical types were distinguished: Afebrile tuberculosis, ten cases, either with miliary involvements or with cavities. These children, varying in age from four to fourteen months, first presented diarrhoea, vomiting and emaciation; they were thought to be dyspeptic or athrepsic. Febrile tuberculosis, twelve cases, with elevation of temperature, bronchial rales and souffles. They appeared to have pneumonia or broncho-pneumonia. In some cases there were gastric disturbance, prostration, a typhoid state, so that a diagnosis of typhoid fever or meningitis was made. Ordinary ulcerating phthisis, two cases, resembled that of adults. In nurslings all these varieties develop more rapidly than in older children or adults. Tuberculosis in children, as is well known, has a tendency to become generalized. In certain children measles, whooping cough, the grippe and diphtheria had a most aggravating influence. Professor Haushalter, also is an advocate of the tracheo-bronchial origin of pulmonary tuberculosis, which localization is strong proof of infection by inhalation. Osler points out the frequency with which pulmonary tuberculosis follows measles and whooping cough. Tuberculosis in children, says Haushalter, is rarely localized, but nearly always generalized.

Heart Complications in Diphtheria.

Dr. Hibbard (Boston Med. and Surg. Journal): The results of the post-mortem examinations in the seventy-two cases are largely drawn upon in formulating the following conclusions:

1. A rapid pulse rate in diphtheria is to be dreaded. Death usually results when it exceeds 150.

2. A slow pulse—60 in young children—is a sign often of serious heart troubles.

- 3. Irregularities in the pulse occur in about 10 per cent. of the diphtheria cases, and are generally significant of cardiac complications.
- 4. A systolic murmur at the apex is heard in about one case in ten, and its prognostic value depends upon the nature of the cause.

5. A bruit de galop in diphtheria is a most fatal sign.

- 6. After four weeks with no heart symptoms in diphtheria, there is little probability of subsequent cardiac trouble in the convalescence.
- 7. All diphtheria patients who have tachycardia, bradycardia, irregular or weak pulse, a systolic murmur at the apex, vomiting or any paralysis—especially palatal—should be kept quiet in bed.
- 8. The most important element in the treatment consists in absolute rest in bed.
- 9. The vagus nerve in the fatal cases always had some evidence of degenerative changes. The weight of the heart was increased.
- 10. The cause of death is usually from cardiac thrombi, dilatation or paralysis, produced most probably by the toxin of the diphtheria bacillus.

Obstehries.

Salivation Due to Retroflexion of Gravid Uterus.

Dr. Audebert (La Gynecologie) reports a case where the patient was a secundipara; there had been septic symptoms after her first labor. Hypogastric pain continued till she again became pregnant in November, 1895. Early in the following December the patient noticed that her mouth was full of saliva, yet she was not troubled with nausea. This symptom grew worse and worse, and dyspepsia and dysuria set in. There were only two fits of vomiting, quite accidental, all this time. In February, 1896, in the middle of the third month, the uterus could not be detected above the pubes, and the anterior lip of the softened cervix touched the pubes. Behind the cervix a soft mass continuous with it filled the pelvic cavity. Attempts at reduction gave great pain and the uterus remained fixed. But a day or two later the patient was placed in the genu-pectoral position; then the gravid organ was easily

reduced. By means of a pad in Douglas' pouch the uterus was retained in its normal position. Immediately after reduction the salivation rapidly diminished, falling from 810 g. on the day before to 160 g. next day, ceasing entirely at the end of three days. The pregnancy thenceforward proceeded normally.

Comparative Study of Ether and Chloroform in Parturition.

Dr. Hensen (Sem. Med.) announces that the superiority of ether over chloroform for the narcosis of parturients resides in the fact that while both suppress the action of the abdominal muscles, the effect of the ether rapidly passes away and the uterus resumes its contractions in five to twenty minutes, while the effect of chloroform is felt for a couple of hours, preventing contractions and thus favoring the expulsion of the fœtus and favoring hemorrhage from atony of the uterus. numerous tests with primiparæ and others, covering several years, were made with a bulb in the uterus connected with a barometric tube. He found that the energy of the uterine contractions increases progressively till the rupture of the bag of waters, to subside then until after the expulsion of the fœtus, when the pressure increases again to reach its highest point, a remarkable phenomenon which may be due to the increase of thickness in the uterine wall at this moment. He found that five milligrams to two centigrams of morphine have no effect upon the contractions of the uterus and of the abdominal muscles.

Atrophy of Uterus Resulting from Vaporization.

Dr. Baruch (Centbl. f. Gyn.): The excellent results obtained by vaporization of the uterine mucosa in cases of hemorrhage and septic endometritis have brought this method of treatment into prominence. It should, however, not be forgotten that the remedy is accompanied by great risk, and should be used with much caution, as the following case illustrates: Patient, twenty-seven years old, had a spontaneous delivery at term. During the puerperium there was an elevation of temperature, beginning on the fifth day, in consequence of which the patient was detained in bed three weeks. Menses returned four and a half months post-partum, and the bleeding continued eight A physician "vaporized" the uterus, which brought the bleeding to an immediate cessation, so that the patient felt perfectly well, and could resume her household duties at once. Since then, however, menstruation did not return, and the woman suffers from all the reflex symptoms of a sudden menopause, the time elapsed since the treatment being nearly two years. The uterus is hard, unusually small, retroposed, and adherent with its entire posterior surface. An attempt to measure it with a sound failed, owing to complete atresia of the cervical canal. The fallopian tubes are not palpable, and the ovaries are felt only indistinctly; so that the result of the single treatment was complete destruction of the endometrium, followed by the usual pathological changes resulting from such complete destruction.

Treatment of Puerperal Infection with Aromatic Essences.

According to the Rev. de Cienc. Med. de Barcelona this method of treatment meets with "surprising and immediate success." A single thorugh application should be followed by a fall in the temperature in a few hours and without observing any secondary effect. Turpentine or essence of bergamont is used, and the author was led to attempt the treatment by his success in treating infected ulcers and wounds with turpentine. The essence is applied on a wad of cotton, inserted with curved forceps and the intrauterine surface painted with it, squeezing the essence well into the tissues, but never leaving it permanently. No speculum is required, although a preliminary vaginal irrigation is advisable. This treatment has been applied to all cases at the Maternity and in his practice for over a year, with invariable success. One application a day is sufficient, except in case of gangrene or diphtheritic patches. He begs those who wish to observe the results of the treatment to apply it first in cases of infection of the vulva or entrance to the vagina, when they will see the aspect of the ulcerations alter before their eyes. Wherever applied the fall in the temperature is constant.

Characteristic Pulse Curve of Gonorrheal Puerperal Fever.

Dr. Singer (Arch. f. Gynecol.) comes to the following conclusions based upon thirty-five cases, which he has collaterally investigated with regard to the part played by gonorrheal infection:

1. The formation of puerperal thrombi is heralded by a stepladder rise of the pulse several days before the appearance of other symptoms. The acme of the curve coincides with the completion of the thrombus.

2. The thrombus curve is entirely characteristic.

3. In a typical thrombus pulse-curve, the temperature remains normal. When edema appears, or a thrombotic cord is perceptible, or lung symptoms are apparent, the pulse is at its maximum, and the temperature begins to rise. The temperature should fall within a few days, while the pulse continues high.

4. There are deviations from the above form. For example: The pulse and temperature may rise together, this signifying

an inflammatory thrombus.

- 5. If an inflammatory thrombus occurs, the secretions of the parturient woman should be carefully investigated.
 - 6. In many such cases gonococci are found.
- 7. If a severe puerperal fever of thrombotic origin occurs in a woman spontaneously delivered, and if gonococci are present, such fever would not be regarded as ordinary puerperal fever, and the attending physician or midwife should not be held in any way responsible, unless they had made internal examinations.
- 8. In the treatment of puerperal thrombosis, early recognition is the vital point. Hence careful study and registration of the pulse-curve, and comparison with the temperature, are indispensable.

9. The patient should neither get up nor sit up too early. It is a good rule to lie in bed three weeks after the pulse becomes normal.

Erotic Hallucinations after the Menopause.

Dr. Charpentier (Annales d'Hygiene publique et de Med. leg.): A woman of fifty-five applied for treatment, saying that, though she was after the climacteric, she feared she was pregnant. She said she had a connection with a man, and since then she had unmistakable symptoms of pregnancy. She was so convinced of it that she confessed her sin to her son. The doctor examined her and persuaded her that there was nothing the matter with her, and later he found out that the connection she spoke of was also a myth. But in a few months she returned to him with the same fear. He knew another old lady of sixty-five who had such strong erotic desires that she had to seclude herself completely for fear of yielding to her passion. She told the doctor that while her husband was alive she was, on the contrary, of a very cold temperament. Dr. Charpentier thinks that erotism is rather rare during or after the menopause, but Dr. Vallan asserts that there is no period in woman's life in which erotic desires and hallucinations are more frequent.

Local Treatment of Puerperal Infection.

Dr. Jewett (Jour. of Obs.): An essential preliminary to the local treatment is an accurate knowledge of the seat and character of the local lesions. A pelvic exploration should be made immediately there is reason to suspect the existence of infection. It is a grave mistake to curette and douche the uterus when the disease is confined to the parts below it.

Septic vaginal wounds are to be cleansed once or twice daily, and touched with tincture of iodin, or with a 50 per cent carbolic or chlorid of zinc solution. Lacerations extend-

ing into the broad ligament should be cleared of blood-clots

and packed with iodoform gauze.

Vaginal douching is useful in the presence of foul discharges. To a mild non-toxic antiseptic there can be no objection, if properly used. The peroxid of hydrogen or a 1-in-10 glycozone solution is suitable. Douches, however, ought to be given only by the physician, and with all the care

observed in a major surgical operation.

No active interference within the uterus should be undertaken till assured that it is involved in the septic process. Tardy involution and an abnormally gaping cervix are presumptive evidence of a septic or putrid endometritis. The most definite information is afforded by the fingers in the uterus. It is difficult, however, to render the hand aseptic, to say nothing of the risk of carrying infectious material from the vagina. To the trained hand the dull curette is almost equally satisfactory as a means of exploration and is safer. The odor of the uterine lochia can be learned from what clings to the curette. The presence of decomposing blood-clots or of fragments of placenta or membranes calls for the immediate and complete evacuation of the cavity with the curette.

While the curette and the douche, rationally employed, are valuable resources in the treatment of puerperal septic endometritis, their empirical use as routine measures has doubtless

done incalculable harm.

In the absence of debris in the uterine cazity the curette is contraindicated. In purely septic, as distinguished from sapremic infection of the endometrium, painting the entire cavity of the uterus with tincture of iodin, or with 50 per cent carbolic or iodized phenol solution is recommended. The uterine wall, and subsequently may cause fatal bleeding into normal salt solution or with a mild antiseptic—e. g., iodin water. Finally, a loose packing of iodoform gauze is left in the cavity, to be removed in twenty-four hours.

In virulent forms of infection little or no benefit is to be derived from local measures. By the time the indication for treatment presents, the offending germs have passed beyond

the reach of curette and douche.

Carossa of Bavaria places a soft drainage tube in the uterus, and about this as a center packs loosely with absorbent gauze. A rubber tube and funnel are attached to the drain, and every four hours about eight ounces of 20 per cent to 25 per cent alcohol are slowly passed through the funnel.

Kahn reports excellent results in nine cases of puerperal endometritis treated with intrauterine injections of steam. The uterus is first cleared of blood-clots and remnants of secundines. The steam is injected through a perforated metal tube. The tube is passed through a cannula, which serves as a guard to the vagina and vulva. Steam at a temperature of 100° C. is used for two minutes, when the temperature is raised to 115° C. and allowed to act for fifteen seconds. The steam is an effective germicide, the blood and lymph channels are effectually closed by albuminous coagulation and a protective coating is formed over the new granulation tissue.

Use of the Hand in Obstetrics.

Dr. McLean (Gyn. and Obst. Jour.): The author expresses the belief that the tendency on the part of certain writers on obstetrics to discourage the use of the hand for purposes of diagnosis and treatment during labor is hardly justifiable. The teaching that the obsterician may not be so much as make a digital examination of the parturient patient, without great danger of infection, says the author, tends to discourage the cultivation of that tactus eruditus, "which can be so highly developed in the human hand, and can never be safely supplanted by unfeeling steel."

For purposes of diagnosis, the sterilized hand may be carried far enough into the vagina to ascertain the condition of the passage, and the size, condition, position, etc., of the child. In doubtful cases the insertion of the fingers into the vagina is not sufficient, as the tissues about the superior strait cannot be satisfactorily studied without the free introduction of the whole hand. The writer has found that a normal internal conjugate will just accommodate the hand with all the finger joints flexed, except the metacarpo-phalangeal joints, the bulb of the thumb being pressed firmly against the second joint of the index finger. The measurement taken in a direct line from the phalangeal joint of the thumb to the second joint of the little finger will be found to be just four inches; and the points named, the knuckles of the flexed thumb and the flexed little finger, will be found to be the points which come in contact with the sacral promontory, on the one hand, and the pubic symphysis, on the other. If the pelvic diameter be reduced and admitting only the same points, i. e., the same impinging joints of the thumb and little finger while the extremities are all extended, a measurement of three and a half inches in diameter is the result. Should it be necessary to withdraw the thumb, and so bring the outside of the metacarpo-phalangeal joints of the index and little fingers in contact with the bony points of the pelvis, a diameter of three inches is obtained. The measurements gotten by contact—measurement through the middle joints of the three fingers, index, middle and ringwill be found reduced to two and one-half inches. The longer diameters of the superior strait, oblique and transverse, may be approximately estimated by abducting the thumb from the fingers in the first position. The presentation and position may be settled with a certainty which no other means can, by any probability, offer. And as irregularities in the position of the head constitute a large preponderance of the difficulties in cases of dystocia, it is here that the intelligent use of the hand will do the most valuable service. Having learned, beyond reasonable doubt, that the parturient canal is normal, the fingers carried up about the nape of the neck, and thence, swept forward, to the helices of the ears, the exact position of the occiput may be at once learned beyond doubt. The relative size of the head may be also learned, so that the proportions of the passage may receive their due valuation.

For correction of faulty positions of the presenting part, or for the application of forceps, nothing is so safe or simple as the use of the fingers. To the objections that the frequent occasions for invading the canal with a meddlesome hand can be productive only of mischievous results, may be answered that "a well-trained hand is safer within the mother's body than any mechanical instrument; and what shall be said when

the instrument is in an untrained hand?

"But, it will be objected that the danger of introducing septic germs with the hand is such as to offset any probable good to come of such manipulations. To this we simply say that the operator who is unwilling or unable to sufficiently sterilize his hand for obstetric operations is unfit to be trusted at the other end of an instrument of steel—boil he it never so wisely!"

The danger of the introduced hand in coming in contact with the raw and bleeding surface of the uterus is thus answered by the author: "The hand will not come in contact with the raw and bleeding surface of the uterus, but with the waterproof and germ-proof membranes of the amniotic sac."

While the necessity for careful aseptic precautions is not underestimated, the writer would "Educate the hand as well as the head, that its delicacy of appreciation of every abnormality, its incomparable skill in manoeuvering for the welfare of the sufferer, may not be driven from the field, because it is easier to boil an iron instrument than it is to take a conscientious bath."

To Preserve the Perineum.

Dr. Oliver (Am. Med. Surg. Bull.): It is my practice to introduce two fingers of the right hand into the vagina, and with each pain stretch the perineum in advance of the head. I have often found extreme rigidity disappear in a few minutes

under this treatment. The patient's attention being occupied by the severity of the pain, no objection is ever raised to this procedure. When the head begins to distend the vulva the real work begins, but full expansion has by this time been secured.

Two fingers are introduced behind the occiput, and this part of the head is brought well down under the pubic arch. The diameter of the head passing through the outlet will thus be materially lessened, and so also will be the tension on the perineum.

Surgically clean cloths, wrung out in hot water, applied

directly to a tension perineum often secure good results.

Cynecological Pląhings.

Cancer of the Breast.

Dr. Rodma (Charlotte Med. Jour.) advises operation in all kinds of mammary growth. The statistics for the year of six American surgeons (Keen, Bull, Dennis, Weir, Halsted and Powers) show a mortality of less than I per cent.—six deaths in 656 operations. He concludes with the following summary:

1. All mammary growths should be removed at once, for innocent tumors, carried for a long time, become a menace.

2. The complete operation should always be done in cases

of malignant growths.

- 3. In nearly every case it is simply impossible to detect enlarged glands in the axilla before it is opened. Keen says he cannot do so once in ten times.
- 4. The mortality should be, with average operators, about 3 per cent.
- 5. A radical operation promises from 25 to 50 per cent. of permanent cures, according to the time when the patients apply.

6. When in doubt operate; never wait for symptoms.

Symphysiotomies One Does Not Do.

Under this title Queirel, of Marseilles (Annales de Gyn.) describes seventeen cases of labor in women having pelves deformed to some extent, in which at some time during labor it seemed probable that delivery by symphysiotomy would be necessary. In each of these cases, however, the patient was safely delivered either by spontaneous birth or by a comparatively easy application of the forceps.

It is unnecessary to quote these cases in detail. The pelvic contraction in none of them was pronounced, and all would have been suitable cases for symphysiotomy. A number of the mothers had lost children in previous births by craniotomy or in prolonged spontaneous birth. The point which is emphasized by these cases is the fact that the only test of labor is careful and intelligent study of parturition itself. It is absolutely impossible from pelvic measurements only, or from previous history alone, to say definitely that a woman cannot be delivered without a given obstetric operation. Each case of abnormal pelvis or of abnormal foetus demands careful study. pelvis should be measured, and every effort made to appreciate the relative size of the foetus. The mother's general condition, her age, her strength, and the circumstances in which she is must also be taken into account. A decision must then be made, either to interrupt pregnancy or to allow it to go on to its natural end. When labor occurs the operator must stand prepared to assist nature, and the success or failure of the labor will depend, not so much upon the obstetric operator chosen as upon the selection of the right moment for operating, the abstaining from efforts which cannot succeed, and the scrupulous and aseptic care given to the patient.

Suture and Ligature Material.

Dr. Gordon (Journal of Medicine and Science): In the opinion of the writer the aseptic quality of silver wire entitles it to preference over nearly all kinds of non-absorbable ma-Silkworm gut would come nearer to this than any Silk is perhaps more generally used than all other material of this class. Some surgeons claim that silk should not be classed under non-absorbable material, but too many instances of fistulous openings continuing until the ligature or suture has appeared are evidence to invalidate such a claim. Slikworm gut can be impeached on similar testimony. Halstead uses no absorbable suture. If I understand this distinguished surgeon correctly, he would prefer absorbable sutures, provided he could be sure of freedom from septic germs. I may misunderstand his position. From all data at hand I have nearly reached the conclusion that the profession generally would for most purposes prefer absorbable material for both sutures and ligatures if they could be satisfied on two points:

1st. That it would not be absorbed until it had accomplished the object for which it was used, viz., retain the parts in apposition until complete union had taken place, or in case of ligature of a vessel until it is safe from hemorrhage.

2d. That the material is absolutely aseptic at time of use and will remain so until absorbed.



Assuming the second proposition proven, let us examine and see what is absolutely necessary to hold the parts in apposition and how long it is necessary for a suture to last to do Repair of tissues when wounded, everything being aseptic and the parts accurately approximated, is a perfectly normal, physiological process, simply a regeneration of tissue. If no strangulation takes place (i. e., interference with the circulation) repair begins at once, and in twenty-four hours union is established by a plastic material which consolidates rapidly and becomes permanent. If by any means the surface could be retained in contact without the intervention of sutures, the reparative process would go on much more rapidly, because no part of the circulation would be vexed by the pressure of suture. Warren in his Surgical Pathology and Therapeutics, under the article "Process of Repair," says: "Formerly the changes brought about in the tissues, by means of which repair was effected, were supposed to be caused by inflammation. It was thought that a smart inflammation was necessary to glue the lips of a wound together. Aseptic surgery has demonstrated the error of this view, and it is now known that the two processes are quite independent of each other." further shows that while actual repair will take place in aseptic wounds in a very few days, yet complete solidification requires about three weeks. Therefore, while superficial wounds will require sutures but a few days, deep-seated ones, like abdominal section, may need suture material that will last longer.

It does not follow from this, however, that sutures need be buried if non-absorbable, for they will act to a greater or less degree as a foreign body and attract round them an exudate to encapsulate them—a material much less durable than normal repair tissue. The absorbable materials for sutures and ligaments are catgut and kangaroo tendon. Dr. Marcy of Boston has used the latter for many years, and is fairly entitled to all the credit pertaining to its introduction; his reports have been carefully presented to us, and no one can question that in his hands it has been very efficient. My own experience with it has been limited and my observation among my colleagues does not encourage me to use it any more. It may be that it has not been carefully prepared or properly used. My chief objections to it are the short strands, preventing over-and-over suturing, which I do very much in hysterectomy, and the possibility of its remaining unabsorbed too long and producing fistulous openings. I know of many instances which may be due to faulty technic. Doubtless catgut is used more extensively than any other of the absorbable materials. Its chief merit in my experience is that it rarely fails of absorption; it is

elastic, so that if a suture be drawn too close at first it soon gives enough to prevent strangulation of tissue. In this way one can do over-and-over suturing, an important thing where hemorrhage occurs in parts where much difficulty is experi-

enced in ligating vessels in other ways.

The objections which are urged against its use are, first, the fear of infection, owing to the extreme difficulty of rendering it strictly aseptic. So great is this fear that such men as Halstead absolutely refused to use it or have it used by their assistants. Halstead claims that no specimen he has examined is free from pathogenic germs. Another objection is that if it is rendered absolutely sterile the fibre is to a great degree impaired and loses its strength. A third objection is that it absorbs too soon and the tissues separate before complete union takes place. While the fear of infection is paramount with some, in my opinion by far the larger number object to it on the ground that it does not last long enough to prevent hemorrhage or to hold deep-seated tissues in apposition until union is solid. It is a very common expression among surgeons of my acquaintance, "I should like to use catgut, but do not dare to. I am afraid of hemorrhage, etc." The feeling begins to be general that an absorbable suture is the ideal one, and one by one are coming to its use.

Since 1894 I have used no suture or ligament that was not absorbable with the single exception of silkworm gut, and that only for closing the abdominal wound; in this latter case I include all the tissues with the silkworm gut, commencing from within and bringing the needle out, threading the other end and carrying it in the same way through the opposite side; this I believe is a preventative against stitch abscess, as I rarely see one; all other ligatures and sutures are from catgut. In hysterectomy I use the over-and-over suture from beginning to end of the operation, and nearly all ligatures used in the pelvic cavity are carried through tissue by a needle and tied afterward. This is done to avoid slipping, which is so apt to occur when catgut is used in the ordinary manner. In commencing a hysterectomy I include a portion of the broad ligament, and after ligating as strongly as possible I carry the needle below the point of ligation through the ligament, tying to the free end already used in the first ligatures. In this way I secure the ligature from slipping from the ovarian artery, an accident that often happened before taking this precaution; the over-and-over suture is continued from that point on to and including the uterine artery, which I secure in the same manner. If the abdominal walls are thick I usually stitch the fascia with an over-and-over suture of very small catgut.

may not be necessary in ordinary cases, but seems best in the cases described. In finally closing the abdominal wound the silkworm suture should be drawn well up and tied just close enough to fairly approximate the surfaces, but not tight enough to depress the skin or in the least strangulate the tissues. Within two or three years I have allowed these sutures to remain at least two weeks and then removed every alternate suture, allowing the balance to remain from three days to a week more. By this method the parts are kept from any strain and hernia is almost unknown; in my opinion this is a very important step in its prevention; rarely is there any redness in appearance even at the end of three weeks.

For radical cure of hernia I have found the buried mattress catgut suture to be sufficient, especially since I have made the incision freely above the internal ring. One modification of this operation both from the Bassini and Halstead I have made which I like, and shall repeat it in a favorable case. Instead of closing the canal by buried sutures and then placing the cord between the surface and the fascia and closing the fascia over it, as in the Bassini, I placed the cord above the fascia after closing it separately, and then closed the fatty and connective tissue which lies between the fascia and skin over the cord (by catgut) instead of closing the skin over the cord as in the Halstead operation. This left the cord free from the skin and prevented adhesion to it. In all previous operations I have seen more or less swelling of the testicle, both in the Bassini and Halstead. I did this in this cease because the fascia was thin and was closely bound down to the edge of the canal, so but little room was left after the canal was closed. I feared if I did the Bassini operation it would press too hard on the cord. The result was no swelling or soreness was found in the testicle, and the patient recovered with no discomfort from these usual complications. Catgut is the only suture that would have fitted such a condition without producing more or less strangulation. I do not know of any case of failure in hernia operations which was in any way fairly attributable to the catgut suture. I do not use the chromicised gut for the reason that in many cases it is so hard that it will not absorb, and if by chance it should not be absolutely sterile very great harm would have come from the operation, and even were it sterile and nonabsorbable a foreign body is left which interferes with free circulation of the part, hence with perfect nutrition and repair. Our object in hernia operation is to close the ring and canal perfectly throughout, and it is safe to assert that two or three weeks at most are sufficient for this. Well-prepared catgut will certainly last that time when buried,

hence nature's own union, when perfect, must be stronger than any artificial union; all exudate thrown out around a buried nonabsorbable suture must be of much lower vitality than normal repair tissue, and consequently must be much more easily absorbed, thus rendering parts less resistant to pressure from within. The operations for hernia by injection of stimulating and corrosive remedies produce an exudate which lasts for a time, and the patient is led to believe a cure is effected; but most of them give way after a time, the exudate having been absorbed. So far I have been entirely satisfied with the buried catgut suture, closing the canal, transplanting the cord by one or the other methods resorted to and uniting the skin by an over-and-over fine suture or by Marcy's subcutaneous. Successful operations for hernia would seem to be as good a test as any operation in surgery, and if an absorbable suture accomplishes firm union of the tissues one cannot wish to leave a foreign body, which, if it does anything, must do harm by interfering with normal circulation, surrounding itself by an exudate of low vitality. I have used catgut in all operations about the uterus and vagina, both for recent lacerations and those more remote from parturition; and if at any time I have had partial failure it has doubtless been due to some fault in technic rather than to the catgut. I am sure that I have had many less failures from catgut than from the nonabsorbable suture. There is this to be said, however, on the other hand, that when I used silver wire we were not doing aseptic surgery. Perhaps one of the very strongest tests for the catgut suture is in the operation for cleft palate. This I have done repeatedly and as a rule with absolute success, never having had a complete failure since I began its use.

Among my earlier operations for perineorrhaphy, like every one, I used silver wire, but frequently removed it in four or five days, and found everything well united, even in cases of complete lacerations; indeed, the first case of complete laceration for which I operated I ordered the sutures to be removed at the end of the fourth day. It proved a success, but I confess that subsequently I did not dare repeat. All of us have seen how much the wire sutures cut the tissues when left a much longer time than this; the fault in part no doubt was that twisting them too close did not allow for the effusion of serum from the denuded surfaces producing swelling

from the denuded surfaces, producing swelling.

In cases of vesico-vaginal fistulae I have had no opportunity of trying catgut, such accidents having almost gone out of the domain of surgery. I should certainly try it should occasion offer. For closing abdominal incisions I should not attempt to do it without the aid of the silkworm gut, to be

retained longer. Some surgeons have had good results even in this operation with absorbent material, closing each layer separately. I think, however, they have used mostly the kangaroo tendon. I do not recall a case of hemorrhage following the ligation of arteries where the accident was clearly the fault of the catgut, unless it may have been due to the fact that the ligature slipped from the tissues more easily than silk would have done. More care should be used in tying, otherwise slipping may take place. In using it for small vessels embedded in muscle or other heavy tissue, the threaded needle is much to be preferred, as I have before said. It is a matter of very much importance to secure pure aseptic catgut, for here lies the principal danger, if we are not sure of the material. My own preference for the commercial gut is the preparation known as Am. Ende's, which comes to us in alcohol. I use it from the bottles as it comes without any boiling or further preparation. All efforts to more completely sterilize it have in my experience but served to weaken it, and so far as I know or suspect there has been no septic influence from it. usually uniform in quality and strength, and, while expensive, one can feel that it is safe to use for all purposes.

The conclusions are:

1st.—All suture material unabsorbed must necessarily have more or less exudate about it.

2d.—Such exudate is of lower vitality than normal repair, where tissues are just approximated and not strangulated.

3d.—That a few days only are necessary to ensure repair if there is no infection, and therefore in cases where no great amount of strain exists absorbable sutures only are needed.

4th.—Where continual strain on the parts is inevitable nonabsorbable sutures should be used for at least two weeks, but should be so placed as to be removed.

5th.—For such sutures the silkworm gut seems to be the best, as it can be made sterile and kept so.

6th.—For all other purposes catgut is sufficient.

7th.—That inflammation is always destructive to complete repair.

8th.—That inflammation is always due to infection.

9th.—That sterile catgut or kangaroo tendon should therefore fulfill all indications for suture or ligature material, with exceptions named.

Parturient Rents of the Vagina.

Dr. Walton (Am. Med. Monthly): Three cases of vaginal laceration seen by me have led me to think that the possibility and seriousness of this lesion are not sufficiently appreciated.

Of twelve prominent authors on gynecology and obstetrics not one fails to elaborate the subject of perineal lacerations, but six of them absolutely ignore the vaginal lacerations, and of the remainder who mention the lesions only two or three seem to attach any importance to them. These lesions are, in some cases and by far the most dangerous cases, found to exist independently of the perineal lesions. For this reason I shall

briefly invite your attention to their consideration.

Case I.—A woman had gone to the eighth or tenth day after her confinement uneventfully, when suddenly the pulse and temperature rose to the alarming height of septic invasion. The perineum was intact, and the attending physician called me to curette the uterus, as he believed that organ to be the seat of the infection. While pulling down the cervix I discovered a large clot protruding into the vagina through a rent in the lateral fornix. Removing this, my finger entered a cavity containing a thrombus the size of a goose egg. The clot was disintegrating, had a foul odor, and was evidently a source of infection entirely unsuspected. Treated on ordinary surgical principles involving drainage and disinfection, the patient made a good recovery, though the symptoms were uncomfortably alarming for the first two or three days. This was a forceps case.

Case II.—Three days after confinement I was called to see a woman who wished me to examine her perineum, which had been pronounced injured by the attending physician. I found a laceration extending nearly to the anus. While cleansing the vagina preparatory to closing this perineal rent, I found an independent tear, two inches in length, extending from the cervix along the lateral wall of the vagina and involving its muscular coats. A continuous catgut suture closed this concealed and unsuspected rent, and its repair was simultaneous with that of the perineum. This, too, was a forceps case.

Case III.—After patiently waiting for a primipara to extrude a tardy head I carefully delivered with short forceps, removing them before the head passed the vulva. A slight rupture of the perineum was apparent as the head came through. What was my surprise when examining the vagina to find it split through nearly its entire length. As I had the head under perfect control and saw the fourchette give way but slightly, it seems to me that this rent was made from above downward, and not, as usually occurs, from below upward. The ordinary surgical means gave the usual result.

These cases teach that a vaginal rent may be the locus of purperal infection; that it may exist when least expected; that it is not a prima facia evidence of careless use of forceps; that the tactus eruditus is not always erudite; that the digital eye is frequently myopic; that the parturient vagina should be considered to be injured until proven to be intact; that ocular

inspection should follow every parturition; that the obstetric sin of omission should be condemned as severely as that of commission. I doubt not that many a life has been sacrificed upon the altar of false modesty, and I do believe that every such death should be charged to the criminal carelessness of the accoucheur. The day has gone by when the obstetrician should walk by faith. The "evidence of things not seen" must be confirmed by the evidence of things seen, or the substance of the thing hoped for when he makes out his bill may not materialize.

Some Common Mistakes in Gynecological Diagnosis.

Dr. Webster (Atlantic Med. Weekly): Symptomatology and clinical history are determinate and often cannot be distinctly cor related with various lesions. Other than local factors must be taken into account. Of chief importance among these is the neuropathic state. A neurotic condition may be developed from causes foreign to the pelvis, and this may manifest itself in intense pain referred by the patient to the pelvic lesion. In another set the symptoms of pelvic pain are developed as one of the phenomena of a neuropathic state, there being no local lesion of any kind.

Mrs. H. complained of pain in the bladder and was treated for cystitis without success. Cystoscopic examination showed a normal mucosa except a congestion of the right ureteric orifice. Palpation of the loins revealed an enlargement on the right side. Bacteriological examination of the urine showed the tubercle bacilli. Operation resulted in the removal of a tuberculous kidney.

Another case is cited in which painful micturition was an early symptom of locomotor ataxia. A chronic parametritic abscess had symptoms of cystitis. A Russian lady doctor was treated for cystitis for some time without success. Examination showed a small fibroid on the anterior uterine wall, near the attachment of the bladder. Cancer of the rectum gave symptoms referable to the coccyx, which was excised under the belief that coccygodynia was the trouble. Papillomata of the bladder may give rise to hematuria, which may often suggest the kidney as the source.

Catarrhal Erosions of the Cervix in Multipara.

Dr. Munde refers to catarrhal and endo-metritis in the multiparous married woman and occasionally in the vagina, with hypertrophy of the glands and papillae of the mucous lining of the cervical cavity sufficient to force apart the lips of the os to a degree scarcely, if at all, distinguishable from the eversion produced by a laceration of the cervix, and is described in the older books as "granular and cystic degeneration of the cervix."

The treatment advised is the excision of the diseased tissue to the depth of half an inch in a converging direction, leaving the cervical cavity funnel shaped. The raw surfaces are brought together by sutures of wire or catgut.

Posterior Division of Cervix in Dysmenorrhea.

Dr. Keith (Therap. Gaz.) says that in the way of prophylaxis nothing is so important as to keep the feet warm. Great attention should be paid to this point, and if a growing girl shows a tendency to cold feet she should be dressed warm and have a hot-water bottle at her feet at night. The general health should of course be attended to. Exercise in fresh air and the avoidance of too exacting lessons are important. As soon as the menses make their appearance, if the girl shows any symptoms of dysmenorrhea, she is to be kept constantly in bed and not allowed to get up until the pain is entirely gone and the flow is either over or almost so. A large poultice should be kept over the abdomen as long as there is any pain. A saline draught at the commencement, with a mild diaphoretic and a small dose of potassium or sodium bromide will prove very serviceable.

When the dysmenorrhea has lasted for some years this general treatment will not often effect a perfect cure, but it should nevertheless be tried in all cases where the pain is not very severe for six months or a year, and it should be explained to the patient that this treatment is not meant for a temporary relief only, but is expected to cure permanently. Little difference exists as to the general treatment of such cases, but the opinions as to the general treatment vary very greatly. Some recommend the use of stem pessaries; some advocate dilatation, slight or great, with or without curetting, and some say the best results are obtained by lateral or posterior division of the cervix. The author highly recommends a modification of the last method—namely, posterior division of the cervix with stitching. This modification makes such a great difference in the results that it is practically a new operation. What is aimed at may briefly be described as the straightening out of the uterine canal and the healing of the cut surfaces by first intention, so that there will be no hard tissue or any possibility of the old bend returning. The most essential part of the operation is the accurate stitching together of each half of the wound made when the cervix is divided. Performed with the uterus in its natural position i. e., without drawing the cervix to the outside—with the aid of a Sims' speculum three-quarters of an inch across, it can be done without rupturing an ordinary hymen, but it is not an operation to be undertaken by those who have not the required dexterity. By this operation, the author says, nothing is left to chance, and unless the cuts do not heal the cervix remains permanently in the position and of the shape it is left at the time of the operation. All the cases he has operated on in this manner have been cured or improved; not only as regards the dysmenorrhea was the effect good, but also as regards the general health. Where an operation is absolutely refused, electricity by Apostoli's method will do good.

Safety in Anesthesia.

Dr. Maduro (Philadelphia Polyclinic): "The Petroleum Ether Mixture of Schleich for Anesthetic in One Hundred Cases." The advantages that he observed are the following: 1. Freedom from choking sensations, such as occur during ether anesthesia. 2. Rapidity of action. 3. Comparative freedom from the state of excitement; the unusual occurrence of asphyxia. 4. Infrequent collection of mucus in the throat. 5. Increase of pulse tension. 6. Absence of persistent vomiting in most cases, which, according to Gherardi, is the only cause of ventral hernia after laparotomies. The absence of vomiting has been especially noticed after a short operation. This mixture has been given with perfect safety and without bad results in chronic bronchitis and in valvular lesions of the heart.

The following are the formulae of this Schleich mixture:

Mixture I. (Boiling point, 38 degrees C.) Chloroform, 45 parts. Petroleum ether, 15 parts. Sulphuric ether, 180 parts.

Mixture II. Boiling point, 40 degrees C.)
Chloroform, 45 parts.
Petroleum ether, 15 parts.

Sulphuric ether, 150 parts.

Mixture III. (Boiling point, 40 degrees C.)

Chloroform, 20 parts. Petroleum ether, 15 parts. Sulphuric ether, 80 parts.

In the above formulas petroleum ether signifies purified benzine, having a boiling point between 60 and 65 degrees C.; and by "sulphuric ether" is meant the ether (95 per cent. oxid) of the U. S. Pharmacopeia. The boiling point of the mixture is the point upon which Schleich lays great stress. He asserts that when the boiling point is higher than the temperature of the blood the quantity of an anesthetic necessary to narcotize is less than when these are equal; furthermore, that the narcosis is much greater with a given quantity of the anesthetic when

the boiling point of the latter is greater than the temperature of the body. Hence the nearer the boiling point of the anesthetic approaches the body temperature, the less likely are unpleasant results. The boiling point of chloroform is 65 degrees C., of ether 34 degrees C. By mixing ether and chloroform in definite proportions with the addition of benzine, Schleich has succeeded in producing anesthetic mixtures of any desired boiling point; the use of which, he claims, gives the rapidity of chloroform with the safety of ether, with quick recovery, and a minimum of unpleasant results. Dr. Maduro had collected in the neighborhood of 1,000 cases in which these mixtures had been given by Schleich and others, and the general result of which seemed to be quite favorable.

Hyperemesis Gravidarum.

Dr. Richard Frommel (Centralbl. f. Gynak.): In dealing with cases of hyperemesis we have not only to consider the few cases in which the vomiting during pregnancy is of the more malignant type, and from which dangerous results are to be anticipated, but also with the much more frequent condition in which heavy and very depressing vomiting takes place -without being due to any malignant condition—and hence much less dangerous. The valuable observations of Kaltenbach have shown us that the former serious cases of true hyperemesis are greatly due to some nervous disturbances. but this explanation does not hold good in the ordinary vomiting, which so frequently, to a more or less degree, accompanies pregnancy. In these cases we are still compelled to attribute the cause of this disagreeable and sometimes very distressing vomiting not so much to the nervous system as to the stomach. We are not yet in position to explain how pregnancy during its development stimulates the gastric parietes, thereby causing vomiting; but the fact remains that in our efforts to relieve the same, we have at all times endeavored to give remedies which tend to act upon the stomach. Of similar character is orexin, which was first discovered by Paal and recommended by Penzoldt as a gastric stimulant.

Frommel reports four cases of young pregnant women whose ages ranged from 20 to 30 years, in which orexin was used. Two were primapares, one was pregnant for the second and the other for the third time. Two were in the third, one in the fourth and one in the fifth month of pregnancy. The two who were pregnant for the second and third time respectively had during their previous pregnancies vomited the whole time they were "carrying." The one that was pregnant for the third time stated that she had become greatly emaciated during her previous pregnancies owing to the persistent vomiting.

In all four cases the effect of the treatment with orexin was very prompt. In two of the cases the vomiting completely stopped after it had been administered for two days; and in the other two the vomiting soon decreased, and completely ceased in less than a fortnight. A fifth case was treated by an assistant in the same manner, this being a young woman in the sixth month of pregnancy, who had become very emaciated owing to the continued vomiting since the beginning of her pregnancy. In this case the administration of orexin proved equally prompt in relieving hyperemesis.

Frommel recommends the further use of orexin in cases of ordinary hyperemesis gravidarum, and that it should be given in doses of three grains two or three times a day, followed by

a little cold water or milk.

Clamps Applied to Uterine Arteries for Fibroids.

Dr. Gouilloud (Ann. d. Gyn. et d'Obst.): After making a circular incision about the cervix, as in vaginal hysterectomy, Dr. Gouilloud separated the bladder in front and the rectum behind from the uterus. Then seizing the broad ligaments in long clamps a distance of two inches the wound was closed in part. After forty-eight hours the clamps were removed. Two years later the patient was in good health, periods had become normal, and the depth of the uterus had diminished by almost two inches.

Primary Tuberculosis of External Genitals.

Dr. Paoli (La Gynecologie) reports five cases of this affection, which he regards as less rare than is commonly supposed. He believes that the disease is frequently communicated directly during coitus, the primary seat being in the region of the vestibule, whence it extends gradually to the surrounding tissue. It is distinguished clinically by ulceration with hypertrophy of the labia. It runs a chronic course, and remains localized for a long period, the general health being but slightly affected. The inguinal glands are often not affected, contrary to the prevailing opinion. Microscopically, intense congestion and inflammatory infiltration are noted; caseous degeneration is rare and spontaneous repair is the rule. Secondary tuberculosis of the external genitals extends more rapidly and exhibits a more malignant character. The treatment is surgical, extensive resection of the affected tissues being necessary. A considerable portion of the urethra may be removed without unpleasant results.

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THE PERINÆUM, ITS TREATMENT DURING AND AFTER LABOR.

BY HENRY B. ESMOND, M.D., F.R.S.SC., ENG.

Before speaking of the treatment of the perinæum, it would be well in this early stage to quote the words of Dr. Gaillard Thomas, who says: "If we ever intend to inculcate true, rational and reliable precepts, we must regard the perinæal body as a triangular concavo-convex body, with its apex superiorly composed of strong elastic connective tissue, that fills in the space between the anterior wall of the rectum posteriorly, the vaginal wall anteriorly, and the summit of the vagina above. This elastic connecting pillar is itself under the influence of, and is supported on, a set of muscles, the tendency of whose action is to throw the perinæal pillar upwards and forwards, thus assisting in the support and closure of the vaginal canal.

- "(1) It sustains the anterior wall of the rectum and prevents a prolapse of the bowel, which, did it occur, would inevitably drag downwards the upper vaginal concavity, and with it the cervix uteri, and destroy the equilibrium of the uterus.
- "(2) It sustains the posterior vaginal wall, and prevents a prolapse of this partition, which would favor rectocele.

- "(3) Upon the posterior vaginal wall rests the anterior, and upon this the bladder, and against the bladder lies the uterus; all of which depend in greater degree for support upon the perinæal body.
- "(4) It preserves a proper line of projection of the contents of the bladder and rectum, and thus prevents the occurrence of tenesmus, a frequent cause of pelvic displacements. It is truly 'the Keystone of the Arch' on which the uterus is supported in the pelvis."

Considering then the importance of the perinæum as a part of the female generative apparatus, it is not to be wondered that oft-times the accoucheur has a "mauvais quart d'heure," especially when the head is painfully stretching the perinæum in primipara with strong expulsive efforts, when he has all his work to do to guide the head under the pubic arch, and prevent that laceration which constitutes so great a present source of annoyance to the accoucheur and future pain and discomfort to the patient.

Now, considering the structure, position and function of the perinæal body, what is the most rational treatment to adopt to maintain its integrity in an ordinary primipara, where it is presumed the expelling and resisting forces are harmoniously balanced? To begin with, when called to a woman in labor, after carefully making a vaginal examination to ascertain the state of labor, condition of os, presentation of fœtus and condition of vagina and adjacent soft parts, the perinæum should not be touched until the presenting part, usually the verte, distends it and the vulvæ; then the patient, being placed in the left lateral position, and having ascertained and carefully seen that the rectum and bladder are empty, lubricate the perinæum and soft parts well with carbolized oil, vaseline or other suitable emollient, and apply a warm, soft napkin over anus and perinæal body; then place the palm of right hand over perinæum, with cloth intervening, so that the thumb lies parallel but external to right labium, and that the ring and little fingers parallel but external to left labium, the index and middle fingers being placed over the fourchette to support the fœtal head and prevent too rapid expulsion thereof; then, without absolutely resisting the descending head, push the perinæum

forward toward the pubis so as to stretch it and distend the sphincter ani, whereby the length of the perinæum is greatly increased; then by repeating this at each pain, and desisting during the interval so as not to create reflex and useless pains, the perinæum is thus stretched, and the head passes outwards under the pubic arch often without even a rupture of the fourchette, or at most only a slight rent thereof. The head having been expelled, care must be taken in extracting the shoulders, which often lacerate the perinæum even after successful expulsion of the head.

Another method is that of Dr. Goodell, of Philadelphia, who, inserting two fingers into the anus, stretches the anal sphincter towards the fourchette, thus relaxing the perinæum in this way, which, however, is objectionable and disagreeable to both patient and accoucheur. The old-fashioned method of supporting the perinæum, or trying to dilate the vaginal orifice by pulling the perinæum backwards, cannot be too strongly condemned, as is also the method of lateral incisions parallel to the raphé.

In ordinary labors affected by the natural forces, the writer has found in attending about 500 cases the best possible results following the first method, even lingering cases due to rigid perinæum eventually terminating satisfactory with no other rent than that of the fourchette, but in cases of multiparæ suffering from cicatrized perinæal laceration, or from faulty driving power, faulty condition of pelvis, malposition or excessive size of fœtus, and small or rigid vulva, other treatment must be adopted. In the case of faulty driving power there may be too much vis à tergo, in which case a whiff or two of chloroform will regulate the expelling force.

Faulty pelvis, or too narrow a pelvic arch, may drive the head backwards on to the perinæum, or too rigid a coccygeus may diminish the perinæal plane. In each of these cases patience and a careful application of the forceps will often save the perinæum fairly well; the same applies to old cicatrized perinæal bodies, which should be well fomented and anointed by some antiseptic emollient before the vis à fronte of the forceps is applied. The two greatest causes of ruptured perinæum, however, are malposition and excessive size of fœtus, and

of these two malposition is the greater cause. In case of large fœtus there is often a want of vis à tergo, in which case, if the fœtus is to be delivered alive, then forceps must be applied, and for this purpose either Barnes' long or Tarnier's axis traction forceps is the best kind. The forceps having been applied, and granted a normal presentation, with great care the perinæum may be saved, by a gentle pendulum action of the forceps, imitating Nature as much as possible during each pain, the head may in this manner be so elongated and moulded as to permit of it distending the perinæum, which should then be relaxed as described at first, and the handles of the forceps drawn towards the mother's abdomen, well between her thighs. whereby the strain on the perinæum is minimized, the head extracted closely under the pubic arch and the perinæum saved. In the cases of malposition, however, the condition of things is more serious, as in frontal presentations, where, as the head descends, the occiput distending the posterior part of the perinæum, often commences a rupture at the anus, which extends through the whole length of the perinæum to the fourchette as the head passes out under the pubic arch.

In the case of small or rigid vulva, if chloroform will not relax the parts, then, as a last resource, relieve the tension by making two or three lateral incisions.

After Treatment.

If the perinæum be not ruptured, then nothing need be done for the first 24 hours; afterwards foment the labia and perinæum 3 or 4 times daily with warm water containing iodine, iodoform, carbolic acid, permanganate of potash or corrosive sublimate or other suitable antiseptic, to enable the local congestion to subside; where there is slight rupture apply a plug of lint soaked in either the above antiseptics, and renew after each ablution; but in case of rupture, whether partial or entire, involving or not the anal aperture, as soon as the labor is completed first cleanse, then bring the torn parts into immediate apposition by means of deep-seated silver or silkworm gut sutures; then introduce into the vagina a plug of antiseptic absorbent wool to keep the maternal discharges away from the injured parts, and carefully renew the plugs occasionally without disturbing the parts, apply a pad of thymol wool to the

perinæum, supported by a light perinæal bandage, and keep the thighs together by lightly tying the knees; introduce an opium or morphia suppository up the rectum, and keep the bowels closed for 3 or 4 or even 7 days, and then to be emptied by an emollient enemata, or, better still, an enemata of olive oil (warmed) may be used every other day, which obviates the passing off hardened fecal masses as well as soothing the injured and inflamed tissues adjacent to the rectum. The urine should be drawn off by catheter 3 or 4 times daily, or a self-retaining catheter may be left in the bladder so that the patient may ease herself at her own convenience. Care should be taken in maintaining the dorsal decubitus for at least a fortnight, and the sutures removed at the end of the first week, when the torn tissues should have thoroughly united.

It should be the first axiom of an accoucheur that the instant he discovers a rent of more than one inch in the perinæum, he should immediately set about to restore it by sutures, as to postpone the operation until after the patient has got over the child-birth period is not justifiable, as so much of the happiness and comfort of a woman depends upon a sound perinæum, the absence of which produces immediate and remote ills in the form of various displacements and prolapsus of the uterus, due to want of the support of the perinæum.



UTERINE INERTIA AND OXYTOCICS.

BY A. W. BLUNT, M. D.

Read before the American Institute of Homeopathy, June, 1898.

"Be fruitful and multiply" was a divine command given at the dawn of humanity. If this is still to be heeded in modern times and the curse, "In sorrow shalt thou bring forth children," be removed, it is our privilege and prerogative as progressive physicians to render these possible, and through our science and art make gestation, from beginning to end, devoid of all preventable pain and danger both to mother and child.

During a practice of over twenty years I have been especially interested along this line of professional work, and led to study carefully and clinically certain phases of obstetrics bearing intimately upon our present topic.

Realizing first that uterine inertia is a special manifestation of deficient or dormant nerve force in a particular organ, we can better apply our remedies if we determine some of the essential and underlying causes leading up to it, and through proper prophylaxis make the results obtained still more valuable.

If first called while our patient is in the throes of puerperal eclampsia we realize vividly what tremendous energy is going to waste in an exhibition of strength, even in the weakest subject, which, if exerted in the right way and direction, would be capable of carrying her through any number of childbirths.

Aware that the sympathetic system is the great storage battery of nerve power, whose erring forces may manifest themselves in countless reflexes, our endeavor must be to keep the circuit free and connections unbroken to every part dependent upon it, so that at the proper time everything may work in harmony, and no reaction follow that cannot be readily and easily controlled.

Inheriting a highly sensitive organization, the girl of to-day, owing to false systems of education at home and school, may easily develop faults of nerve action that have, if not corrected, a permanent influence. The failure, especially at puberty, on

the part of parents and guardians to recognize properly temperament and tendency, and provide for the newly awakened functional activity adequate safeguards is responsible for much of the pain and suffering of after years.

The intense strain on the woman in society often exhausts vital force, and brings with it an attendant train of ills that, in their effect on the uterus and nervous system, render her incapable of the high mission of motherhood.

All these adverse forces in the exercise of our calling we shall have to meet, and endeavor to make the community relaize how much depends upon our skill and foreknowledge in securing for each individual case the appropriate treatment and immunity from suffering.

We shall find in hygiene and sanitary science important allies in securing muscular development and equipoise of nerve force during the preparatory stage.

The selection of remedies according to indications will be of valuable service in many cases. I mention a few that I use most frequently: Cimicifuga, acting so markedly upon the cerebro-spinal nervous system, exerts direct control over many of the reflexes so annoying in the early months. Toward the latter part also I often give it as a preparatory remedy with a great deal of confidence.

Caulophyllum is a close analogue, and is to be thought of where the pains simulate those of true labor. In rheumatic patients it is especially indicated.

Pulsatilla should not be forgotten as a reinforcer of muscular tissue, particularly in those of its characteristic temperament.

Helonias is our vegetable iron, and is to be given where signs of anaemia are manifest. Where the appetite and assimilation are poor, with general weakness and debility, Strych. Phos. 3x, after meals, has made a decided change in many of my patients.

When all that can be has been done, and the expected time arrives, we should be on the lookout for any signs of inertia or faulty nerve action. Where the pains do not progress steadily and uniformly, it should be determined whether there is any mechanical obstacle to delivery, adhesions or rigidity of the os. Hydramnios, or excessive uterine reaction, may also be a cause of the inertia. In fact, as complete a diagnosis as possible should be made of the actual condition and state of the patient and surroundings.

In primiparae no one expects as rapid progress, and a certain amount of delay incident to the first stage should not make us too anxious to hurry it along, preferring to hasten slowly for the sake of the soft parts.

As it is in multiparae that we are more apt to meet with inertia, per se, our oxytocic measures and remedies find a wide field, and the use of every adjuvant compatible with the safety and comfort of our patient is certainly legitimate midwifery. Hot cervical douches, sitz baths, or even the hot, wet pack, have their time and place in relaxing tissues and calming nervous irritability.

We may speak in passing of rectal injections of glycerine to clear the bowel, and also for some slight oxytocic effect.

In the second stage the vis-a-tergo may be aided by manual pressure or resort to changes of position, particularly kneeling, will excite or renew action.

The list of remedies with special symptoms is rather long, but I find more frequent use for Caulophyllum or Cimicifuga for the aggravating, teasing pains at the beginning. Bell., spasmodic closure of the os; Gelsemium, atony, with widely-dilated os; Ipecac. or tart-emet., where nausea and vomiting are present.

But first and foremost among the oxytocic remedies that I have learned to rely upon for several years is Strychnia, administered hypodermically. As stated by one author, "Strychnia has a more powerful influence over the nervous system than any drug in the Materia Medica." It produces by reflex action contraction of the capillary system and of unstriped fibres. The tissues become pale and have their temperature and blood supply lowered. The effect of large doses in producing spasm might lead us to believe that it would act according to our law of similia, and, given in proper doses, be capable of converting inefficient and intermittent uterine action into one regular and normal in character. My experience with it in a large number of cases has led me to take

this view of it, and the longer I use it, the more thoroughly I am convinced that it covers the phenomena of labor better than anything else I have ever used, especially from the beginning of the second stage to the close of the third. have watched carefully for any untoward effects, but have failed to find any, even in a single instance. Particularly in cases of multiparae I now go with more confidence in my ability to overcome depression and inertia and shorten the duration of labor. Used after the membranes have been ruptured, its power over the muscular tissue of the uterus is not long in asserting itself. In twin labors inefficiency of action is a frequent complication; here it is a friend in need. Two particular illustrations of this occurred recently. A lady called on me shortly before her confinement, stating that previous labors hac been very lingering, and accompanied in every instance by severe haemorrhage, several times narrowly escaping death. This being her sixth pregnancy, she was very apprehensive on account of increased size and greater debility than ever before. I gave her cimicifuga, 3x, before, and Strych, phos. 3x, after meals. In about two weeks labor came on, and I delivered her of six-pound twins. The pains seemed weak and irregular at first, and she was quite low-spirited; one-thirtieth gr. Strychnia, hypodermically, made a perceptible change in both conditions, and further on another similar dose completed the work. She lost very little blood, and made a quick, uncomplicated recovery.

In another case of twins labor occurred at the eighth month, the fourth within six years. There was marked inertia, and aggravating pains were felt almost entirely in the left groin. After rupturing the membranes I gave a hypodermic injection of Strychnia, and within an hour both children were born. The mother said she felt stronger than after the previous times. All have continued to do well.

Within the last two months I have used it in the cases of two primiparae, aged 29 and 35 years, respectively. Both had marked swelling of face and limbs, with 50 per cent. albumen in urine, at the time of confinement; yet both went through in a normal way. The Strychnia, besides regulating the pains, acted as a diuretic also, and the oedema rapidly subsided.

In a recent case, also of puerperal eclampsia, I had a happy experience with it. Was called in consultation where the physician had been in attendance constantly for over twelve Found a primipara seven months along, whom he stated had had sixteen convulsions of the severest type during his stay, and another occurring soon after my arrival showed me clearly their nature and gravity. She had been unconscious for hours, and the little urine that could be drawn was solid albumen. On examination I found the os but little dilated and no other signs of labor. We decided that her only salvation was to bring this about, and I suggested the use of Strychnia. Her previous treatment had been injections of morphia, with inhalation of chloroform, also Verat-vir., when she could swallow anything. Strychnia, one-thirtieth gr. hypodermically, was given; two hours elapsed before another spasm, this much lighter than the others. In the meantime, there was some indication of uterine activity, and the os about one-half dilated. I ruptured the membranes, and gave another injection of the Strychnia. The pains grew harder almost immediately; there were no more convulsions, and in less than two hours the child was born. She did not regain consciousness until next day, but her recovery was rapid and uneventful.

The only puerperal case I have ever lost, a primipara, 38 years old, was from this cause, and, while the results might not have been any different, as I look back on it now, ten years, I only wish I had known the value of Strychnia.

In the third stage of labor, when we fear inertia that may result in haemorrhage, I have found it invaluable. Given during the second stage, the action is prolonged into the subsequent one. I have not had a case of retained or even delayed placenta since using it. The womb contracts promptly, and the pressure and kneading formerly practiced so invariably I no longer find necessary. Very little blood is lost, and so much strength saved for the puerperium.

Chloroform may be considered as an oxytocic, at least indirectly. This I administer in nearly every case, never omitting it in primiparae in the latter part of the second stage. Its relaxing and soothing effects are too well known to need any comments. I find it works well in conjunction

with the Strychnia; that if in any case the action of the latter should be to produce too severe contraction, which is very seldom, the chloroform can be used in such a way as to control them nicely, with no danger of heart failure.

I have less use for the forceps than formerly, although, when occasion calls, they become an oxytocic aid we could not well dispense with.

In conclusion, I will sum up the principal points I would make in regard to Strychnia:

- 1st. It should be used hypodermically, thus insuring prompt effect.
 - 2d. Its action is homoeopathic to the phenomena of labor.
- 3d. It shortens the duration, especially of the second and third stages.
 - 4th. The placenta is quickly and easily expelled.
 - 5th. Post-partum haemorrhage is reduced to a minimum.
 - 6th. Secures prompt involution.
 - 7th. Acts as a diuretic.
 - 8th. Reduces temperature.
- 9th. Renders condition of patient stronger after labor, thus insuring more rapid recovery.

I hope that others have had an experience similar to mine, and can testify to its virtues in these conditions. Though we may not understand everything about its action, yet, like Galileo's world, and the principles of our own Homoeopathy, "It does move."



MALNUTRITION.

BY P. J. MONTGOMERY, M. D.

Read before the American Institute of Homeopathy, June, 1898.

Many things are known, or better understood, by comparison, a negative cannot be understood without some knowledge of the positive. Malnutrition is the opposite of nutrition. It is therefore necessary first to understand something of nutrition. Thomas, in his "Medical Dictionary," defines nutrition thus: "The assimilation or identification of nutritive matter to or with our organs. It is the most general property of organized bodies, for all the anatomical elements partake of it, and it characterizes life or vitality more than any other vital property."

Animal life, like the life of the plant, is dependent on light, moisture, air and heat.

Animal life, being of a higher organism, demands these elements in a purer form—sunlight, pure water and air rich in oxygen and modified heat. Besides these, the plant, to give it life, strength and beauty, requires a part of the dust of the earth, while the animal life demands for its maintainance and development the life of the plant, or lower animal life.

If the "soil" is poor, no amount of light, water and air can produce a vigorous plant.

The horticulturist or agriculturist who does not know what "soil" is good for certain plants is a poor nurse to nature. The first great lesson for the mother to learn after the clothing is how to feed her child, for, notwithstanding nature has made a great provision in the lacteal secretion, we find cases where this comes as far short of being what the new animal life requires as sand does for the plant, and far too often this fountain of strength and happiness to the child is "dried up."

If from time to time the child is weighed and "found wanting," no time should be lost to discover the cause. If the food is good, the atmosphere pure, and other things as they should be, we must look for some defect in the organism, some malnutrition.

It has been said to know the disease is half the cure, but

as we live in a time when no one is satisfied with half-way work, the investigation must be pushed till the cause is found.

There is a specific cause for every pathological condition; that specific cause may extend far back, beyond the knowledge of the patient or parent; then the physician has nothing to guide him except the shadowy lines from effect to cause. If we are called to see a child that has been losing weight, looks sallow or pale and old beyond its days, is peevish, its sleep fitful, has a lean, shrunken look, the lustre gone from its eyes, the laughter from its lips, and the temperature is abnormal, we have a case of faulty nutrition, or we may use a Latin word with a French prefix and call it a case of malnutrition. By this we mean something has been, or is, preventing cell formation, and nutrition no longer keeps pace with the waste. If the cause be improper food, the child has a lean and shrunken look, though it may be overfed; the abdomen is distended with gas. or may be in a collapsed state. The stomach and intestines are to the animal life what the roots are to the plant and tree. If the skin is dry and wrinkled, and has a senile appearance, and the eyes look like burned holes in a blanket, you should look to the glandular system for the cause, and back of that a syphilitic taint. If the child is weak-anaemic-and fading like a poor garment in the sun, the eyes the only bright spot on this dark record, then look to the sanitary conditions and surroundings; the child may be breathing more sewer gas than oxygen, or a little later you will discover the terror of the present day—tuberculosis—the pathognomic symptom of which is a rise and fall in temperature in every twenty-four hours, and the waste far exceeds the nutrition.

The nutrition of the body, that is, the maintenance of the parts in a fit state to perform their function, depends on three main factors—the supply of suitable food, the assimilation of food and the prevention or control of the waste.

Nutrition, in the widest sense of the word, comprises digestion, circulation, respiration and secretion; in the digestive fermentation of the food, where decomposition stops combination or assimilation begins. The conversion of a portion of that filthy substance in the intestines called chyme into that pure, wholesome, life-giving substance called chyle

is a process beyond the chemistry of man. The combustion of air in the lungs, the oxygen coming in contact with the blood and giving it its garnet hue, has a touch of mystery about it, known only to nature, or that invisible hand that paints the rose.

The circulation of the blood, as it rushes to every part of the body, and slows up at the surfaces, and then flows back to the heart and lungs to be renewed and reinforced with nutriment from the secretions, and starts again on its endless round, carrying to every tissue and substance of the body some specific cell like its own to nourish and renew, has a slight-of-hand performance never yet seen through.

The saying that we are "wonderfully and fearfully made" has a new meaning to the physician, for the more he knows about the construction and function of the human system, the less he wonders, but more fully realizes, how fearfully easy it gets out of order.

Malnutrition is a disturbance of that equilibrium of forces which nature is forever trying to preserve; it is a disarrangement of that delicate balance which, when perfectly poised, means good health.

The human system is, in its normal condition, a perfect chemical laboratory; a failure in any particular affects the whole chemical composition. The assimilation and elimination, the secretion and excretion must maintain their poise, or nature soon loses the balance of power. It is not only necessary that the system be nourished in every particular, but it must be kept clean, or, like an unswept house, the cobwebs of melancholia soon settle in the brain, and the dust of asthenopia is in the eye, while the coarser debris is dumped in the liver or left to unnaturally swell the adipose tissue. This is what is so often termed the cal-carb. subject (fair, fat and flabby). He has no more stability than the stucco buildings at the Trans-Mississippi Exposition; they are fair to look at, but if you will examine closely you will detect the cachexia of decay from the beginning.

One of the many causes of malnutrition, and by no means the least, is malaria. It impoverishes the blood, destroying to an alarming extent often the red corpuscles, and deranging the renal secretions. The skin is hot and cold by turns, flabby, pale, and bathed with a clammy sweat, more or less profuse.

There is a high and a corresponding low temperature, with general depression of the mental, nervous and muscular systems.

These systems with a worn, weary and tired feeling may continue for months, even years, when some insidious foe in the form of an epidemic attacks the unguarded forces, and the little sufferer succumbs to some organic disease.

In closely observing the ills of childhood you will find malnutrition plays an important role in the development of many diseases of children, especially scrofula. There is often a mistaken idea that the same developed disease is the cause of the malnutrition, while the fact is the reverse. There are but few diseases that will attack with fatal results the well-nourished child.

We all know from sad experience menbranous croup stands first in this small list. Keep the system well nourished, and it will laugh at miasma and grow fat on bacteria.

Prevention is the best way to cure this malady. Right here I am grateful to be able to say that the science of homoeopathy is fast becoming not only a rescuing, but a guarding and defending angel in its ministrations of beneficence toward the human race, and on the higher plans of its development. We may hope to see it stamp out the hereditary taint of diseases that to-day confront us as hopeless cases.



ACUTE INFLAMMATORY DISEASES OF THE LUNGS IN CHILDREN.

BY F. F. WILLIAMS, M. D.

Read before the American Institute of Homeopathy. June, 1898.

When I first began to prepare this paper I thought I knew something about acute inflammatory diseases of the lungs in children, having had over fifteen years' experience in treating these diseases of the little people in the cold northern region, where the sudden and great changes in the weather during the autumn, winter and spring act as an exciting cause of all acute lung affections. However, I thought best to make a thorough study of what the different authors had to say on the subject before writing anything, as I was a little rusty on the technical medical terms from being constantly obliged to get down to plain Saxon in my conversation with ordinary mortals, and from lack of contact with physicians; but before I was through with my reading I became completely lost in the intricate labarynth of classification and nomenclature of bronchitis, capillary bronchitis, broncho-pneumonia, croupouspneumonia, lobar pneumonia and lobular pneumonia, and would find myself constantly referring to the headings of the chapters to see which one I was studying.

My experience has led me to believe that all this excess of fine distinction and classification is ornamental rather than useful, and much easier discovered at the autopsy than at the bedside, hence of but little benefit to the patient or the busy general practitioner, for it is rare to find a severe acute bronchitis without some pneumonia, or a severe pneumonia without some bronchitis, when we consider that "thin partitions do the narrow bounds divide," as between the pulmonary tissues on the one hand and the bronchial apparatus on the other, and that they are so intimately related for the accomplishment of their important vital functions, we need feel no surprise that they make common cause in attempting to resist noxious influences, or that, when overwhelmed, they go down together under a common catastrophe. I have

therefore concluded, after much study in the preparation of this paper, to ignore all minute differential diagnosis and pathological conditions, and speak of all acute inflammatory diseases of the lungs in children, from birth to five years of age, from purely a clinical and practical standpoint, under the head of broncho-pneumonia.

The predisposing causes are catarrhal conditions of mucous membrane, strumous diathesis, dietetic irregularities, and abuses resulting in impaired digestion and nutrition, teething in small children, measles and whooping cough, or anything which lowers vitality and takes away the power to resist disease. The most common exciting causes are exposure to cold, moisture, and sudden changes in the weather from warm to cold and from wet to dry, and the more sudden and severe the change, the more cases of broncho-pneumonia among children, without their having had any known chance for "taking cold." Hence we have many cases from November to May, and but few during the rest of the year. The age at which a child is most liable to suffer an attack is from eight months to three years.

In children the attack is rarely ushered in by a chill, as in adults, or, if there has been a chill, no one knows it. Sometimes a child may seem to have a cold in the head, then the throat, soon the bronchi become involved, and afterward, by extension of inflammation, a full-fledged pneumonia is developed. Again, the child may retire at night feeling usually well or perhaps having a slight cold, and awake in two or three hours with a high fever, rapid breathing and pulse, red cheeks, almost scarlet, and dry cough and pain in breathing, as shown by short, jerky movements, moaning or crying. During the first twenty-four hours auscultation and percussion show but little change in the respiratory sounds other than a hissing or whistling from dryness of the bronchial membrane. After twenty-four hours the respiration becomes more rapid-from forty to eighty per minute—the pulse from one hundred and twenty to one hundred and seventy, and the temperature from 103 degrees to 1054 degrees. The whole lungs sound as if full of mucus, or it may be confined to one side, but not often. The cough becomes loose and perhaps painful. Percussion may

or may not show dullness, as dullness is quite liable to be found late in the attack, when the child has begun to improve, or sometimes not at all. During the height of the disease the little sufferer's attention is entirely taken up with respiration, and he is more docile, and submits to an examination better perhaps than were he in health, for he seems to instinctively know that all his strength is required to keep up the supply of oxygen, and he will remain for a long time in the best position he can find for breathing, saying nothing, but grasping some favorite toy, and only moving when compelled to cough. The entire absence in childhood of any voluntary effort to expel the morbid products of disease is a great hindrance to recovery, as whatever is raised to the throat is swallowed and passed into the digestive apparatus, there to produce new complications, usually in the form of diarrhea. The failure to raise and expel the sputa adds greatly to the danger, as aeration of the blood is additionally hindered, and no therapeutic indications can be obtained from the character of the discharge.

During the height of an attack the patient can be made to take but little nourishment, wanting nothing but water, for sometimes from four to six days, and the parents become very anxious, feeling that the child will starve or die from exhaustion.

The information obtained from auscultation and percussion is less satisfactory in children than in adults. The duration of an attack is from four or five days to as many weeks, depending on the severity of the disease. Convalescence is usually rapid, but, of course, depending upon the child's power of reaction, sometimes being very slow and prolonged. Unless the attack follows measles, whooping cough, or there are some other complications, the prognosis is usually good in village and country practice, the child fully recovering, and one attack does not seem to predispose to another.

In regard to local applications, I usually put a hot flaxseed poultice all over the inflamed parts for the first twentyfour to forty-eight hours. After this oil the chest and back and apply a cotton jacket. Why do I do this? Well, I must confess that were I sick with pneumonia, I should think that I had "troubles enough of my own" without being bothered every forty-five or sixty minutes by the application of a heavy, wet, stinking flaxseed poultice, but it has become an established practice in my locality, and the grandmothers, the old maid aunts and the neighbors, who come to help in the absence of a nurse; also the old woman who has had thirteen children and raised all but eight, and hence knows more than any physician about doctoring babies, must all be kept busy, or they will say to the anxious parents: "That doctor ain't doin' nothin' for that child only jist givin' him a teaspoonful of water every hour, and that wont ever do him no good. If I was in your place I'd send and git Dr. J. He'd do somethin' right off." I know of nothing that will keep more people busy than the application of flaxseed poultices. A little hard on the poor sick child? Yes; but as "a burnt child dreads the fire," I fea: an officious woman's tongue, hence I think discretion the better part of valor. Then, I have seen benefit from poultices in the first stage of inflammation, as the application of heat is homoeopathic. The reason for the benefit I attribute to the fact that the nerves which supply the lungs also have cutaneous branches.

As regards diet, it should be liquid and easily digested, principally milk. If the child is taking one of the prepared foods which has agreed before, make no change. In some cases I have derived great benefit from the use of Murdock's Liquid Food or Bovinine to keep up the strength. If the child is nursing and has done well, make no change; but I have found much trouble in these cases when the child was too weak to nurse, or could not do so on account of rapid respiration, and have been obliged to have the milk drawn from the breast and fed to the little patient with a spoon.

In the medical treatment in the first stage aconite for twenty-four hours, unless some other remedy is strongly indicated. Gels. if much pain on motion, pain in back of head and neck, photophobia, soreness of the eyeballs or nasal catarrh, with medium fever and restlessness.

If child awakes crying, delirious or in a condition like night terror, with red face, brilliant eyes and bounding pulse, Bell. If very high fever, rapid pulse and intense inflammation of the lungs, verat-ver. in appreciable doses. As we get along a little farther in the disease bry. has its place. Its indications are: Child cries every time he coughs. The cough is dry, harsh, rasping and painful, and I have learned to make the little painful groan or grunt at the beginning of each expiration an indication for bry. Of course thirst for large quantities of water must not be omitted.

Ipecac. is called for in loose cough. Whole chest sounds as if filled with mucus, and child swallows each time he coughs. If there is diarrhea with green, mucous stools the indications for ipecac. are all the stronger. Ars-cup. may also be called for if there be present severe, painful diarrhea. Phos. is seldom called for in pneumonia of childhood, but, of course, any remedy may be required if there be present the peculiar characteristic symptoms.

The remedy which I use most frequently, and with the most satisfactory results, is Ars-stib., or tartrate of arsenic, in the 3x trit., four grains dissolved in half a glass of water, a teaspoonful every one or two hours, to which my attention was first called by Dr. W. H. Nickelson, about eleven years ago. I usually begin its use about the third day. Its indications are those given by both ars. and tart-emet. There is restlessness with the thirst and prostration of arsenicum, together with the loose mucous cough, great oppression and haste in respiration, with the crepitant rales of tart-emet. Taking everything into consideration, I have found Ars.-stib. to be applicable to more cases of broncho-pneumonia in child-hood than any other remedy.



UTERINE DISLOCATIONS.

BY REBECCA W. ROGERS, M. D.

Read before the American Institute of Homeopathy, June, 1898.

In the consideration of uterine displacements there are two principal points which at once stamp the subject as worthy of careful thought and study, viz.:—

- (1) The frequency of these disorders.
- (2) The inefficiency of the usual methods of treatment looking toward a cure.

The anatomical location of the uterus and the delicacy of its supports render it peculiarly liable to physiological changes of position. The distended bladder in front may push the fundus up and back, while the loaded rectum behind may from similar reason of pressure push it forward. The constantly changing abdominal pressure from above also subjects this delicately poised organ to varying degrees verging from the normal.

So long, however, as the organ promptly returns to its proper position when the displacing influence is removed is its dislocation within physiological limits, becoming pathological only when the displacement becomes permanent, or when outside intervention is necessary to reduce it. While there are a variety of malpositions to which the uterus is liable—as the different degrees of forward, backward, downward and lateral misplacements—yet "prolapsus and retro-displacements are really the only forms which practically claim the attention of the gynecologist to-day."

Anteversions and flexions are rare, and their cures are quite as uncommon; but the backward and downward displacements are very common indeed, while the usual methods for their relief result in only a small percentage of anatomical cures. To be sure, the large majority of these cases are relieved symptomatically, but the best authorities on the subject claim that the permanent return of the organ to its proper position is accomplished in only about 25 per cent. of cases.

My own experience along this line does not show a greater number of anatomical cures, and while "half a loaf is better than none," yet knowing the probability of a return of the morbid symptoms if the uterus be not restored to its normal position, no physician can feel perfectly satisfied or secure in discharging a patient who has only been cured symptomatically.

True, many women live for years with a misplaced uterus which produces no abnormal symptoms, its existence only being discovered by chance perhaps; but this fact does not preclude the liability of much local and reflex suffering in others differently constituted, and the necessity of prompt and effective measures for relief. The local and reflex symptoms of uterine dislocation are so well known and easily recognized as hardly to require mention, backache, rectal and vesical tenesmus and a general sense of pelvic weakness and weight being the most frequent local expressions, any or all of which are aggravated by standing, walking, lifting or reaching, and all relieved in a very marked degree by the recumbent posture, amelioration from lying down being a diagnostic point of great value in these troubles. Occipital headaches, mental depression and symptoms simulating spinal irritation are perhaps the most frequent reflex expressions of uterine misplacements, while the irritation and impeded circulation incident to these disorders often lead to hyperæmia accompanied by such tissue changes as are expressed by menstruation and leucorrhœa.

Indeed, so able an authority on this subject as J. C. Wood claims that "uterine displacements are ordinarily attended with no distress unless associated with hyperaemia or hyperesthesia." This opinion, it seems to me, is a logical one, and reasonably explains why one woman with a misplaced uterus suffers, while her next door neighbor, with a similar anatomical defect, does not. The growing frequency of these disorders among not only women who have borne children, but among unmarried women and girls, is sufficiently alarming as to make a study of causes one of vital importance. Some authorities on the subject claim that displacements are infrequent before marriage, and most common after child-bearing. While the latter statement is undoubtedly true, yet my experience along this special line of work very decidedly indicates that malpositions are common not only among unmarried women, but

among girls still in their "teens" as well, fully 50 per cent. of the cases ranging in age from 18 to 23 who consult me for menstrual difficulties having some degree of backward misplacement, either causing or accompanying other morbid manifestations.

In the majority of these cases there is no history of forcible displacement from falls or injuries of any kind; indeed, the symptomatology indicates a gradual and insidious onset. Nor does a local examination nearly always reveal an enlarged and chronically congested uterus to account for its dislocated condition. In women who have borne children it is not difficult to understand that sub-involution, laceration of the perineum or relaxed action of the vagina or uterine ligaments would not only permit, but favor, the various degrees of malposition to which the uterus is liable.

But such causes are non-operative, and therefore do not explain the presence of these abnormalities in women who have not borne children. To what, then, are these dislocations due in the class of cases where no exciting cause can be detected? My observation along this line leads me to believe that there are certain predisposing causes sufficiently operative to act as exciting causes in many cases, the most important of which are:

- (1) Deficient or imperfect development.
- (2) Errors in dress.
- (3) Improper body poise.

In this age of intellectual culture, when education is the watchword of the hour, mental training is often accomplished at the expense of normal physical development; for it is a physiological law that the growth of an organ is dependent upon its blood and nerve supply. It is also a physiological law that the organ or organs in most constant and active use demand and receive a greater blood and nerve supply than do the inactive or passive ones. At the approach of puberty, therefore, the maturing uterus and ovaries require greater nutritive attention than previous to this time; else growth cannot be accomplished. But our modern system of education imposes the necessity of a greater and more constant mental application between the years of 12 and 18—those critical years set apart

for the development of the reproductive organs—and what is the result physically?

The brain, because of its continued use, necessarily calls for a surplus of blood, while the inactive but feebly maturing pelvic organs are left with a minimum for their development. In short, they are frequently starved for want of proper nourishment, and cannot grow as nature intended them to; as a result, they are dwarfed, stunted, flaccid and inactive.

The uterus is a muscular organ, and if its muscle fibres are weak, flabby and relaxed, it is small wonder if, as a result of the varying degrees of pressure to which it is subjected, it should topple over or be pushed out of its normal position. Anything, therefore, which interferes with the proper nutrition of these organs, just before or during puberty, must necessarily interfere with their proper organic and functional development.

The method of dress which modern civilization has imposed upon a girl as soon as she has passed the golden gates of childhood is also an active factor in the etiology of uterine displacements; not only the squeezing of the waist by tight bands and corsets, but the sagging weight of heavy, unsupported skirts, all tending to increase the abdominal pressure from above. Small wonder, then, if the flabby, undeveloped muscle fibres of the uterus bow in despair at the additional burden imposed upon their weakness.

Body poise is also a causative factor of no minor importance in these troubles; for if, in sitting, standing and walking, it is the habit to throw the pelvis forward and up, thus making its axis coincident with the abdominal axis, the pelvic organs are necessarily under greater pressure than when normal, and prolapsus and retroversion will be the probable sequence. A little observation along this line indicates that a large majority of girls and women have never been taught the necessity—both from an aesthetic and hygienic standpoint—of proper body poise. Maintaining the normal forward curve of the lumbar spine seems to be the keynote of the whole question; and when the chin advances and shoulders droop, the lumbar curve begins to retreat, "the distance between the strenum and the pubes is shortened and, as a result, the abdominal muscles relax from loss of tension." The abdominal organs must,

therefore, descend to make undue pressure on the pelvic organs which are "normally supported and kept in place by the obliquity of the pelvis and the elasticity of the abnormal and spinal muscles, both of which are maintained by the advancing curve of the lumber spine in the true axis of the body." (Skene.)

The typewriter, the sewing-woman, the lady of leisure and the school girl, all are victims of the erroneous habit of stooping forward while in the sitting posture; and as a result, not only bringing undue pressure upon the pelvic organs, but interrupting the return circulation and nutrition of these organs as well. The maturing school-girl, however, is the one most likely to suffer as a consequence of her daily attitude in the school room; and to this posture, coupled with erroneous habits of dress, I believe is due a large majority of the pelvic troubles among young girls to-day.

In the prevention of these malpositions of the uterus we cannot too seriously realize the importance of proper care during the years of adolescence. "We are born twice," says Rosseau; "once to exist, and again to live; once as a species, and again with regard to sex." From a physical standpoint, therefore, it is not strange that so many girls grow up into suffering womanhood, when we consider the hap-hazard manner in which their physiological second birth usually takes Preparations for her advent into the world as a breathing, eating, sleeping piece of pink and white humanity are carefully and intelligently made, and the best of medical skill is none too good to successfully start the little voyager upon the great ocean of organic life; but when in a few years that most critical time approaches when she is to be born a woman, ready to make her impress as an individual, it is rare indeed that intelligent suggestion or wise counsel tell her of the importance of this period of maturity, or the signposts of danger along its pathway.

Preventative measures, therefore, are of first importance; for in no line of medical work is the old adage, "An ounce of prevention better then a pound of cure" more forcibly exemplified than in this. Thorough, scientific instruction along these lines, coupled with an elastic system of education, proper

dress and body poise, would practically wipe out the tendency to uterine dislocations, or their existence in young girls and non-parturient women.

But, as thousands of cases already exist, such measures must be adopted as will most quickly assist nature to restore her equilibrium. The treatment of these diseases naturally falls under the heading of medical and surgical, or, perhaps, I should say mechanical and surgical; for the internal administration of drugs plays only a minor role in the correction of chronic malpositions, although for the relief of acute congestion, chronic engorgements and reflex pains in connection with misplaced uteri, we could illy spare the indicated remedy. But for the anatomical restoration of the parts the additional help is necessary of such mechanical measures as medicated tampons, pessaries or electrical massage.

For many years the hard rubber pessary was the one mechanical measure used for the relief of these troubles. Fc1 every misplacement a pessary was the one panacea, irrespective of abnormal anchorage due to adhesions, or of the condition of the pelvic tissue to be helped or irritated by its pressure. As a consequence, many patients suffered positive injury from these devices, and their use gradually fell into disrepute as the advent of the medicated tampon dawned upon the medical horizon. The efficacy of this measure as a depletant of congested tissues is beyond dispute; but its usefulness in restoring misplacements is limited by the material used for the tampon, the manner of its placing and the condition of the tissues in and around the uterus. Until recent years absorbent cotton was used entirely for this purpose; but the aseptic surgical wool now specially prepared by Merritt for tampons is far superior, as it does not absorb the secretions or become hard and uncomfortable, as does the cotton, if worn for several hours. It is also softer, more elastic and much more easily removed than the cotton tampon.

After all congested or inflammatory conditions have been dispelled by properly medicated and properly placed tampons, I believe that a well-fitted, soft rubber pessary is not only justifiable, but is a decided advantage in completing the cure of many an intractable misplacement. However, as every

physician knows, there are numerous cases of dislocated uteri not restored by these measures, and the time has come when some measures other than surgical must be offered for their relief. Alexander's operation has not given such universal satisfaction as to be eagerly sought by patients, or offered by the profession of to-day; dilatation, curettage and packing are also uncertain, and ventral fixation has not as yet been adopted as a common measure by many surgeons, even if the majority of patients would be willing to undergo surgical treatment for their troubles—which they are not.

The medical mind is turning more and more to electricity for the relief and cure of many forms of pelvic troubles, and I believe the time is at hand when this agent will be universally known as a most potent one in the restoration of misplaced uteri as well. Experience has taught us, beyond a doubt, that galvanism is the remedy par excellence for uterine congestions, engorgements, erosions, adhesions and leucorrhoea, and after these conditions have been dispelled by the properly selected galvanic current, then a thorough massage of the weakened uterine fibres by the faradic current will so stimulate and strengthen them as to make their normal tonicity possible.

This may be accomplished by inserting one electrode into the uterus and one electrode into the rectum, pushing it well up against the contracted and weakened fibres of the posterior uterine wall; or, perhaps better still, is the bi-polar uterine electrode, through which the primary interrupted current exerts its massaging influence directly upon the uterine tissue. Exercise of any muscle increases its strength and tonicity, and the uterus being a muscular organ can be no exception to the law; therefore upon the intelligent use of electricity have we "a reason for the hope that is in us," for not only the symptomatic but the anatomical cure of the majority of cases suffering from uterine dislocations.

THE URINE IN DISEASES OF NUTRITION.

BY H. W. WESTOVER, M.D.

Read before the American Institute of Homeopathy, June, 1898.

During life we find a continual disintegration and wearing away of cells and tissues, accompanied by upbuilding, and replacing the old by new. This is metabolism.

The kidneys play a very important part in the excretion of the so-called waste products of the body.

Therefore, when the metabolic processes are increased, and at their height, the renal activity must proceed "pari passu" in order to maintain the equilibrium of health.

With increased activity of function, we find an increased liability to perverted action.

As a result of over stimulation, this excessive activity of the cells, or a perverted and abnormal action, may be followed by a decreased ability to perform their task.

These conditions may be simply functional, or if the abnormality continues, they may sooner or later result in structural change, and the further these abnormal conditions become removed from normal, the more difficult becomes the task of securing a return to normal conditions, which is health.

During childhood, cellular activity and tissue changes are far in excess of such process in adults.

Diseases of nutrition place increased burdens upon the kidneys, because when nutrition is at fault there is not only an increased amount of tissue detritus to be removed from the organs of the body, but there is also apt to be a greater amount of unappropriated material to be carried away through these so-called "sewers of the system."

If these conditions are facts, it necessarily follows that the kidneys will be compelled to endure a greater strain than in health, and, like all overworked organs, men or machines, will be prone to perform their functions in a more or less faulty manner.

It is our duty at all times to aid the kidneys in performing their functions when they are called upon for increased activity. We should also try to prevent abnormal conditions, as well as carefully consider them after their occurrence. This holds good in a pronounced degree when treating diseases of nutrition.

It is not enough to note that digestion is impaired, or that the stomach is irritable and almost incapable of performing its functions; it is not sufficient to also observe the character of the alvine discharges.

The careful physician should also consider the indications furnished by the renal excretion.

The examination of the urine of young children, being a greatly neglected subject in text books and journals, is the excuse for calling your attention to it by this paper. It has sometimes been advised to use a small flexible catheter for obtaining the urine.

This method is quite objectionable. A better way is to place a clean flat sponge over the genitals inside the diaper. When it is saturated with urine, the contents can be squeezed into a suitable container, and the sponge reapplied when dry, after being washed in water. However, with care the urine can be obtained direct from children 2 years old, or even younger.

In urinalysis of such cases we should remember the urine of infants contains but a very small amount of phosphates. It is much less in growing children than in adults. Therefore do not consider it an abnormal condition when simply a small amount of phosphates is found.

It is stated indican is practically absent in the urine of infants. "Excepting primary intestinal or general septic diseases, the presence of pathological quantities of indican is indicative of intestinal disturbance."

It is well to remember that an excess of uric acid during the first ten days after birth is not a pathological condition. In later infantile life, during serious diseases of the digestive tract, we are apt to find deposits of urates and uric acid. Sometimes children from three to two months old will cry out or strain during micturition, and the urine will leave a darker stain than normal, and the edges of the stain will show a yellowish pink discoloration, when a careful inspection will disclose a fine sandy deposit. Not infrequently these little patients are unsuccessfully treated for enteralgia. A careful examination of

the urine will show urates, uric acid, epithelial cells, and possibly a few pus corpuscles, thereby enabling us to institute the proper treatment. We will not unlikely find that ferrum phos, or lycopodium, will afford relief, and the colic diagnosed by the mother or nurse will disappear.

In diseases of nutrition we are apt to find a deficient oxidation of tissue, so that the products of metabolism stop at uric acid instead of being converted into the more soluble urea. It is considered by some that this lithæmic state is the exciting factor in nutritional disturbances.

At any rate, we often find it associated with more or less disturbance of digestion, and gastro-intestinal catarrh, or more active inflammation.

The nervous system does not escape, and urticaria and erythema are clearly dependent on it, and I am disposed to believe eczema as well.

For this lithæmic condition we are apt to find lycopodium, mercurius, sepia, sulphur, berberis, etc., the indicated treatment.

Not infrequently in gastro-intestinal diseases of infants the urine is excessively acid, with a pronounced excretion of uric acid, the meatus irritated and even the surrounding cuticle inflamed by the irritating discharges. As has been stated, this indicates imperfect metabolism. Although these patients require deep acting remedies, it is difficult to secure satisfactory results until the character of the urine is improved. A marked beneficial change will often follow the free administration of Buffalo lithia water, but the carefully selected homoeopathic remedy should be continued in conjunction with it lest the relief be but temporary. Whether the lithia water be considered an indicated remedy, a chemical antidote, or a hygienic measure, is immaterial, but it certainly is a valuable aid in treating some intractible conditions, and I think it has saved the lives of some patients for me. I prefer this natural water to that prepard by adding a lithia tablet to pure water, although I would use the latter in the absence of the natural water. Lithium benzoate is sometimes a valuable remedy. According to Shoemaker, lithium carbonate promotes the assimilation and metabolism of nitrogenous material, and increases the elimination of urea."

According to Haig, the changes of elimination rather than formation produce the clinical phenomena.

Usually these patients are nervous, excitable children, well developed mentally, bright and active, but they do not sleep well, are not hearty feeders, and take cold readily.

In entero-colitis there is liable to occur a deposit of urates. Under the microscope this cloudy deposit is seen to consist of opaque globular particles, studded with long sharp spines. This irritating deposit seems at times to cause irritation of the mucous membrane of the urinary tract, probably a mechanical irritation, provoking frequent micturition.

A deposit of urates is easily distinguished from phosphates by the fact that it clears up when moderately heated.

Vesical calculi are generally largely composed of urates. When uric acid is present, heats and albumins should be used sparingly, but water ought to be taken plentifully.

Among strumous children we find a tendency to the excretion of urates and uric acid. This is an indication of deficient metabolism, which should have resulted in the formation of urea, but stopped at uric acid.

We should not regard this as a renal disease, and direct our treatment primarily at the kidneys, but we should rather attempt to increase assimilation so that, as a more healthy condition of the system is attained, the excretion may become normal, and the urine contain urea and no deposit of uric acid, the latter being an uncompleted product.

These conditions are found more frequently among citybred children than among the rural population. Precocious, bright, high-strung children are much more prone to lithuria than the other type. They are less able to withstand the ills of childhood, and require deep-acting remedies and reconstructive treatment to influence the vegetative functions of the economy.

I am in accord with Fothergill, who teaches that this tendency to lithic acid formation, largely dependent on deficient hepatic function, is a legacy bequeathed to the offspring of active, zealous brain workers. The rush and worry of the city, aggravated by the almost universally excessive meat diet, entails upon the children this condition, to be further aggravated by their excessive consumption of meat. These children are not necessarily strumous, but the tendency is that way.

Fortunately they are small feeders, but unfortunately their solicitous parents unwittingly try to tax their feeble livers by urging a diet which adds to the hepatic burden they bear, and increases the tendency to uric acid formation.

Neither do they drink heartily, although an abundance of fluid is needed to carry off the insoluble uric acid, which ought to have been soluble urea.

Although these children are not rugged, but are delicate and neurotic, it is a mistake to try to feed them up, and thus increase their strength and development. We should rather aid the liver by a rather non-nitrogenized diet, plenty of outdoor air and sunshine, and instruct their parents to refrain from stimulating their mental activity, but rather endeavor to keep their brains as quiet and unexcited as possible.

The remedies should be such as assist the hepatic function and aid the kidneys, so the system will excrete urea rather than urates and uric acid.

The condition of the urine in rachitis does not seem to be satisfactorily worked out. Some writers claim the calcium salts are subnormal and the phosphates diminished, some state there is an excess of urates and uric acid, with the appearance of leucocytes, while others hold to the opinion that there is prone to be an excess of the phosphates.

Personally, I have had so little experience with this disease that I can confirm neither of these statements. My observation of the urine in rachitis is limited to one not very pronounced case, which was carefully, but unsuccessfully, treated by persistent efforts to find the indicated remedy, and administer a suitable diet.

Malassimilation was evident, almost complete anorexia, but no great apparent gastric or intestinal irritation. The child was cross, petulant and wakeful, sleep easily disturbed, averse to being fondled, abdomen not much distended, perspiration not pronounced, eruption of teeth delayed. There was hyperacidity of the urine, and at times an excess of urates. Lithia water was given ad libitum, and the remedies continued, when a satisfactory recovery ensued.

The most prominent remedies in rachitis are calcarea phos. and ferrum phos.

Phosphaturia does not indicate renal disease, and is of importance only as showing in a general way malassimilation. Phosphates occur as crystallized calcium phosphates, amorphous phosphates, or as crystalline ammonio-magnesian phosphate. In infantile atrophy the urine is strongly acid, contains an excess of urea and phosphates, is liable to show albumin and is subnormal in quantity.

In leukæmic subjects we may find albumin and leucocytes, with a diminished amount of urea, but expect to find urates and uric acid in excess.

In these conditions do not neglect the lithia water in connection with other remedies.

Oxalate of lime is not infrequently associated with nervous and gastric disturbances; it may occur in either acid or alkaline urine. The disappearance of the deposit is usually accompanied with relief of the other symptoms. Without considering remedies indicated by concomitant symptoms, it is well to remember that in oxaluria nitro-muriatic acid and oxalic acid are apt to be beneficial; lysidine has also been recommended.

The presence of albumin is always worthy of attention, although it does not necessarily indicate an inflammatory condition of the kidneys. It is not infrequently present in cholera infantum, or even in intestinal catarrh, when it is an indication of renal congestion.

The liability of its occurrence in diphtheria and scarlatena is universally recognized and guarded against, but, being foreign to this paper, it will not be considered, except to say that in diphtheria, if the urine diminishes in amount, and the microscope shows blood corpuscles, we expect the diphtheritic process has invaded the kidneys, or that nephritis complicates the case.

The diagnostic significance of urinary deposits of children may be briefly stated as follows:

The urates indicate feeble digestive power or dyspepsia. They may appear from overworked kidneys, and also from granular degeneration of the kidneys.

Uric acid appears as a result of inactivity of the liver, or defective metabolism.

In cystitis there may be a deposit of uric acid. We are apt to find uric acid deposits in fevers and rheumatism.

In leucocythemia there is prone to be an excess of uric acid. Phosphates are liable to appear in excess when there is abnormal tissue waste, or great nervous excitement.

Oxalates indicate an impaired innervation of the sympathetic nervous system, malnutrition and feeble circulation. They often appear in diseases of the central nervous system; at times they are followed by albuminuria.

The oxalates sometimes appear after improper diet. Albumin appears in nephritis, and often in febrile diseases, especially scarlatena and diphtheria.

Any disease causing passive congestion of the kidneys is prone to be accompanied with albuminuria. Blood is indicative of renal, vesical, or urethral disease.

Malarial poisoning sometimes produces hæmaturia.

Mucus in excess shows inflammatory action in some part of the urinary apparatus.

Pus indicates an ulceration or cystitis.

Bile usually indicates an obstruction of the bile duct, but may appear in intermittent fever, or with a disordered liver.

Sugar indicates diabetes, but may occur temporarily in dyspepsia and with hepatic derangement. It is well to remember dysuria is not always an indication of vesical disease. as it may originate from a high fever, and the child cries out when attempting to urinate.



NUTRITION.

BY J. PETTEE COBB, M.D.

Read before the American Institute of Homeopathy, June, 1898.

In selecting nutrition and the disorders dependent in part on faulty nutrition as the subject to be presented, it has not been my expectation that anything wonderful would be evolved; on the contrary, the subject was selected because it is one concerning which a great deal of exact information is at hand; because by a timely and proper use of such information we can avert the larger part of ailments from which children suffer, and because a large part of the profession seems to have overlooked the importance of this subject in their admiration and study of the wonderful advances in surgery and pathology.

Nutrition or assimilation, in a wide sense of the word, is probably the most universal and characteristic property of animal existence. By this term we designate that series of changes through which dead matter is received into the structure of living substance. The term in its broadest sense may be used to cover the subsidiary process of digestion, respiration, absorption and excretion through which food material and oxygen are prepared for living molecules and waste products of activity are removed from the organism.

It is necessary that the animal body shall be supplied with food in order that its normal functions may go on without interruption; the waste of tissues by reason of work must be repaired; potential energy must be stored up to provide for the various kinds of tissue work, viz., motion, heat production, nerve-force and metabolic activities. All of these purposes must be effected without undue waste, without unduly increasing the output, and without unduly taxing the constructive machinery.

That the study and proper regulation of the food to supply nutrition in the most favorable manner for these various purposes in adult life is important, cannot be questioned. That it often means to the infant and child its possibility of existence and always its future capabilities is not so universally appreciated. The average weight of a babe at birth is approximately seven pounds; the baby who develops only at the average rate must double this weight in four months, and must treble this weight in twelve months. This increased weight, startling as it is when compared with any relative growths in the adult, does not mean simply adding adipose tissue and storing up fuel for consumption. It means development of new tissues, reorganization of embryonic tissues and the development of organs for new functions.

At birth the small intestine is only nine feet and five inches long, while during the first two months it adds about four feet to its length. The capacity of the child's stomach at birth is but a single ounce; during the first year of life this capacity is normally increased from eight to ten fold.

In the central nervous system the tissue has, to a large extent, to be made over, the fœtal nervous tissue not having the capabilities for extensive work, being largely of an embryonic type. The changes in the oseous system and the length of time required for the perfection of its development are familiar to you all, and need only be mentioned to be appreciated.

We might go on and enumerate many more striking demands for nutrition in the child not illustrated by any counterpart in the adult economy. Enough has been said, however, to emphasize in a general way the importance of faultless nutrition for the proper development of the child.

The influence of faulty nutrition as an etiological factor in scorbutus and rachitis will be discussed by writers in this section. The excessive tax put upon the eliminating organs by a faulty diet and the relationship of external protection to nutrition will also receive attention. Dyspeptic diarrhœa, one of the sequela of dietary errors and proper substitute feeding in infancy, its direct prophylactic measure, will be presented to you together.

With the aim of presenting the foundation for the special essays to be presented upon Inanition, Malnutrition, Marasmus and Anemia, I desire briefly to call your attention to the various purposes of the different food principles.

One of the best divisions of foods for a study of their uses is that given by Thompson in his valuable work on dietetics,

viz., 1. Water. 2. Salts. 3. Proteids. 4. Starches. 5. Sugars. 6. Fats and oils.

In defining the uses of these different food principles I shall quote freely from Thompson:

Uses of Water in the Body.

- 1.—"It enters into the chemical composition of the tissues."
- 2.—"It forms the chief ingredient of all the fluids of the body and maintains their proper degree of dilution."
- 3.—"By moistening various surfaces of the body it prevents friction."
- 4.—"It furnishes in the blood and lymph a fluid medium by which food may be taken to remote parts of the body and the waste material removed, thus promoting rapid tissue changes."
 - 5.—"It serves as a distributor of body heat."
- 6.—"It regulates the body temperature by the physical processes of absorption and evaporation."

Water comprises about 70 per cent of the body weight; the daily intake and output of water should be about one-fifteenth of the body weight. One of the most universal dietetic failings is a neglect to take enough water into the system for a proper maintenance of the physiological functions.

A deprivation of water shows its first effects in imperfect elimination; a continued deprivation changes the amount and character of the digestive secretions, thus impairing their capabilities. Imperfect nutrition, inability to rid the body of noxious compounds, the result of faulty digestion and tissue katabolism, and obstinate constipation are common results in children fed upon too concentrated food and supplied with too small an amount of water.

Emaciation changes in the blood and in the nervous system will also surely follow from a continued deprivation.

An excessive use of water, a condition which often obtains in children fed upon diluted milks and various proprietary foods, increases the blood pressure, forces the eliminating organs to do an excessive amount of work, which may in the kidneys result in an alteration of their structure and weaken the digestive organs by over-distension. The shape of a two or three months old baby's stomach who is obliged to swallow

eight or ten ounces of fluid to obtain sufficient food for one meal will be materially changed. A dependant diverticulum is formed by over-distension, which at all times contains liquid and partially digested foods flavored with lactic acid, butyric acid and other irritating products of imperfect digestion. Such a stomach never normally empties itself; more or less frequently it will revolt and empty upward what it cannot pass through the pylorus.

Use of Salts are:

- 1.—"To regulate the specific gravity of the blood and other fluids of the body."
- 2.—"To regulate the chemical reaction of the blood and the various secretions and excretions."
- 3.—"To prevent the tissues from disorganization and putrefactions."
 - 4.—"To control the rate of absorption by osmosis."
- 5.—"To enter into the permanent composition of certain structures."
 - 6.—"To enable the blood to hold materials in solution."

An excess of salts may act as a local irritant to the gastric or intestinal mucous membrane; may modify the rate of absorption; interfere with the nutritive and chemical processes of the blood and tissues. Certain salts in excess tend to cause the deposit of calculi and concretions.

Continued deprivation of salts is followed by signs of malnutrition and mental inactivity, and is one of the factors in the development of scorbutus and rachitis.

Proteids.

Proteids are also an absolute necessity, as they supply the material from which the new proteid tissue is made and the old proteid tissue is repaired. The most important constituent of living matter is the proteid part of its molecules, and this can only be supplied by proteid food—a prolonged deprivation of this food principle would result in emaciation and starvation, even though all other food principles were abundantly supplied. Proteids also have an important use in the production of energy; they are complex compounds; they contain a large amount of potential energy, much of which is utilized in tissue metabolism.

The tendency in this country, however, is toward a disproportionately large amount of proteid food, which taxes the eliminating organs by requiring them to excrete in addition to the normal waste of a large amount of proteid derivatives which have served no purpose in the animal economy. This means excessive work for the liver and kidneys, and is recognized as one of the common causes of all forms of lithiasis.

There are on the market many food compounds recommended as milk substitutes which are composed in part of proteid meat extracts and derivatives; they differ in their structure and behavior from milk proteids, and seriously tax an infant's digestive and eliminating organs.

Under their use the feces become more bulky, of a drier consistency, gluey in character, and by their odor give evidence of decomposition of undigested material. The urine becomes loaded with amorphous urates, uric acid and abnormal peptone derivatives; a catarrhal condition of the bladder, with distressing symptoms, often follows; the skin loses its clear, smooth surface, becomes roughened, or even eczematous. The child is irritable, a poor sleeper, and subject to catarrhal inflammation.

I have seen all of this train of symptoms vanish where the child has been put upon a properly modified diet. During the first year of life the proteid element of food should come exclusively from milk; during the second year the proteid element of cereal food can be well digested, but the proteids of meat should not be used before the child is three years old. Starches and Sugars.

Their chief physiological value lies in the fact that they can be destroyed in the body, and by their destruction liberate energy. The energy of muscular work and of heat comes most easily and chiefly from the oxidation of carbo-hydrates. Seven of the thirteen per cent of solids in milk consist of carbo-hydrates.

In preparing a substitute for mother's milk we must bear in mind that an infant who requires 50 per cent of its solids of this character can only use it to an advantage in one form, viz., sugar of milk.

The Uses of Fats and Oils are:

- I.—"To furnish energy for the development of heat."
- 2.—"To supply force."
- 3.—"To serve as a covering and protection in the body."
- 4.—"To lubricate and make more plastic various structures in the body."
 - 5.—"To spare the tissues from disintegration.
 - 6.—"To serve for the storage of energy."

About one-fifth of the body-weight is composed of fat; a large part of this is derived from the carbo-hydrates, but some of it comes directly from fat in the food.

Its importance can be estimated by referring again to the composition of milk, where we find that one-third of the total solids are fat.

Chemical examination of the feces demonstrates that in a child fed upon normal milk nearly one-half the fat is not digested, but serves as a lubricant for the bowel in its work. Human milk has been found to be more often deficient in fat than in any other ingredient. Constipation is frequently the first sign of a deficiency of cream. The addition of cream to the baby's diet is at such times the best remedy.

Again, in early infancy a sudden demand is made for a new physiological activity; up until birth potential energy has been converted into heat only to a minor extent, but with a separate existence this becomes an important function. Cream, next to sugar, is the source from which the infantile organism can most easily and cheaply obtain it.

The points I wish to make are:

- I.—A child's food has more varied and lasting purposes to fulfill than has an adult's.
- 2.—That good health and proper development require certain exactness in the relative and exact amount of different food principles.
- 3.—That as milk, whether human or cows, is not always what it should be, it often requires to be modified or supplemented to furnish the child an economical and sufficient nutrition.
- 4.—That the same care should be given the diet after as during the first year of life.

APPAREL OF THE CHILD; ITS INFLUENCE UPON NUTRITION.

BY P. E. TRIEM, M.D.

Read before the American Institute of Homeopathy, June, 1898.

A prominent writer has said: "One of the most interesting books that could be written would be a treatise on the errors of mankind." Perhaps in no other department of domestic life has there been a greater display of error than in the fashion and material of our garments, whose primary object is to protect us from exposure, as well as to conserve the vital forces within the body. And, indeed, not only have errors of judgment contributed to this fund of health-destroying apparel. but the caprice of Dame Fashion has cast her blight over many an infant's mantle. Does it not seem strange that Nature, so prodigal with all her other creatures, has never so much as provided a stitch for the masterpiece of her workmanship, and, still more strange, that she should have left him with so little judgment in the application of her laws demonstrated in the lower orders of creation all about him? How appropriately it might be said: "Study the warblers of the air that flit about your doorvards, and with their merry songs seek to entice you to their homes. Behold the tiny birdlings, with scarce a feather to cover their quivering forms, so neatly and cosily encased in their cradle of wool and down. It would put many a young mother to shame to study this simple abode, so simple, and yet fulfilling all the requirements of healthfulness.

Not the least menacing problem of modern life has been how to properly clothe the body, and, like all other problems which depend upon evolutionary development, it has never yet been solved to answer the dual requirements of our æsthetic and physical natures. Its first conception was that of a mantle or cloak with which to cover the iniquitous depravity of the fallen race, and, strange to say, that idea, very largely, prevails to the present day. Surrounded by the gorgeous display of Nature's adornments, the idea soon merged into that of ornamentation, which, in time, gave rise to the ever-varying

fashions, diverting the mind from one of the more essential purposes of the garments.

But, as the borders of that primitive family became too narrow, and the ambitious youth began "to reach out for more lands to possess," there was added another element to the requirements of this garment, viz., that of protection against climatic and atmospheric changes, calling into requisition the inventive genius, and invoking Nature's great storehouse to furnish material to supply this need. And thus on down through that ever-varying course of human events has the garment sought to gain a paramount position, until it has rivaled every industry and invaded every land and sea, and, reaching out beyond the body, it has erected palaces and mansions of colossal dimensions and superb decorations.

In order that we may not become lost in this great world of industry, I will invite your attention to the consideration of the apparel of that product of misconception—a wailing infant—so small and insignificant as compared with the whole human race, but bringing to every mother no small world of care.

The apparel of the child in its relation to nutrition involves a very essential consideration of its existence. When we remember that nutrition comprises digestion, circulation, respiration and secretion, its importance, from the standpoint of the physician, will be readily conceded. Experience also teaches that motherly vanity is a vexatious enemy to the rational physician, and, with his best endeavors to fortify the frail constitution against physical inaptitude, he too often meets with signal defeat. It would be impossible to estimate how much of the degeneracy of the human race should be directly attributed to the misapplication of physical agents at that period of child-life when it is so susceptible to external impressions. Yet the thoughtful observer need not search long to find examples which will warrant the assertion that the strongest stamina may be converted into never-ending debility, or pitiable helplessness. Too little stress is put upon the symmetrical development of the body. The nutritive processes may be arrested in some organ or member, and thus the harmony of all the functions, which constitutes

health, is destroyed. From the moment the infant draws its first breath and the circulation assumes an independent course. the task of assisting in the harmonious action of the vital processes begins. The first outcry, hailed with so much delight, is for shelter and protection, and too often is the swaddling cloth converted into the shroud of the infant. Consider for a moment the rapid transition through which the newborn infant has passed. Practically, its whole existence has been in a medium of uniform temperature, much higher than it is likely to meet even under the most carefully instituted methods. The shock to the nerve centres may be sufficient to arrest in part or wholly the nutritive processes, and defective development must follow. The infant's first investment should be a warrant of the sacred obligations of those to whom it has been intrusted. Its first apparel is of greater importance than the inheritance of a fortune in later life. The same conditions obtain through its whole infant life; in fact, it is a succession of transitions, which requires the delicacy of educated hands to insure uninterrupted growth. The apparel of the child must fulfill this first requirement, viz., that of maintaining suitable warmth and protection against changes of atmosphere.

Next in importance to the maintenance of equable temperature is the freedom of muscular action and circulation. Perhaps an illustration can be drawn from the more primitive method known as swaddling, "a tale of the olden time." When the child was completely dressed in its bandages it not unaptly resembled billets of wood or the form of an Egyptian mummy. The skin was sometimes excoriated, the flesh compressed almost to gangrene, the circulation nearly arrested, and the child left without the slightest power of motion. In a word, it had no resemblance to any living thing; its frequent and unavailing cries alone determined it to be human. Such is the description of this relic of barbarism by Dr. William P. Dewees, in 1847. In the light of experience and the progress of science, have we in this year of our Lord 1808 thoroughly divested our infants of this damnable bandage, that often excoriates the skin and compresses the flesh almost to gangrene? There was some ground for plausibility when the whole body was enveloped by the bandage. But the practice loses all semblance to rational procedure when both ends are cut off and the child is bisected cross-wise. The pernicious effects of constriction are self-evident, involving several of the prime factors of nutrition. The garment should be so adjusted that there is freedom of every muscle. There certainly should be no constriction of the thorax and abdomen. The violation of every fundamental law of its being cannot fail to meet with disastrous result to the child. Yet how often do we fail to detect the proper cause of malnutrition. The child begins to fade, and forthwith we analyze its food and the air it breathes. These, indeed, should be pure. But why impose such implicit confidence in the mother's ability to clothe her infant properly, when daily experience teaches us the contrary?

There is still another source of evil in the improper arrangement of the infant's apparel which should not be forgotten. While it may be adjusted so as to meet the requirements of muscular and circulatory freedom, and thereby insure a healthful demand for nutrition the over-zealous mother may have been too lavish in the quantity. Much as we deprecate illjudged exposure, we are inclined to believe that it is scarcely more injurious than over stimulating the tender systems of infants by means of injudiciously applied heat. Heat beyond a certain degree acts like any other stimulus upon the vibratile system of very young children. In consequence of this the different parts of the body do not develop in their most healthy order or in their natural proportions—the whole body is urged to a precocious expansion. We thus invite disease by the destruction or too great a diminution of certain important secretions. The over tenderly brought-up children, "the instant the winds of heaven a little too roughly visit them" become early victims to early diseases, or drag out a protracted existence in which there is neither comfort nor enjoyment. This hothouse plan of rearing children, in consequence of which no organ is prepared to perform its function properly, has ever had more victims than triumphs. A most remarkable instance of precocious maturity is that related of Louis II, King of Hungary. He was born so much before his time as to have no skin. At two years old he was crowned; in his tenth year he succeeded to the throne; in his fourteenth he had a complete beard; he married in his fifteenth; he had gray hairs in his eighteenth, and in his twentieth he died.

Let us draw a few practical conclusions from this general consideration of the subject.

First.—A more thoroughly scientific knowledge of the rerelation of the apparel to nutrition is necessary. This implies the constant supervision of those who are the guardians of the public health, and should be the first object lesson taught to every mother. While, in the main, the natural requirements of the child should indicate to the thoughtful mother the general make-up of its apparel, there are many minor details which she does not understand, or, possibly from personal motives, may be inclined to disregard. The kindly offices of the family physician can be most easily interposed in behalf of the child, and it should not be beneath his dignity to investigate its apparel and eliminate objectionable features.

Second.—Nutrition is a product, of which the apparel is an important factor. Properly clad is often better than well clad. The child will not digest more food, however suitable and well prepared, than it is able to assimilate. Arrested nutrition may come through cutaneous impressions as a result of suppressed or abnormal secretions.

Third.—Abnormal development is no index of health. While the garment should afford suitable protection, it should not over stimulate. To give the child a healthy growth requires such changes as are suited to its successive periods of development. Though the child may be crowned at ten, he will most surely die at twenty.

And, fourth, to obtain perfect results, every detail of the child's apparel must conform to natural laws. Nothing can be more dangerous than the random application of principles that are, in themselves, doubtful. The child is the miniature man or woman. Disturb the harmony of its physical being and you have wrecked a life for which the law of God will demand retribution.



THE HOMŒOPATHIC TREATMENT OF PNEU, MONIA IN CHILDREN UNDER THE AGE OF FIVE YEARS.

BY FRANK A. WATKINS, M.R.C.S., L.R.C.P., L.S.A.

Pneumonia occurring in children under the age of five years is generally of the lobular type, and appears to be determined by the embryonic condition of the lungs, which do not reach their mature or adult state until about the end of the fifth year.

The morbid condition is caused by an inflammation of the bronchial mucous membrane, which by direct extension involves the connective tissue, bronchioles and air cells.

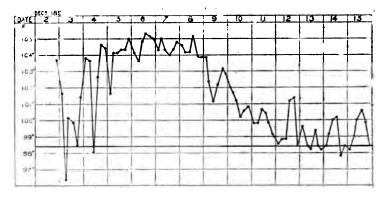


CHART No. 1.

The following is a short extract from the notes of a case of broncho-pneumonia, in which most of the usual signs and symptoms of the complaint were developed.

Mary Collins, aged 1 year and 8 months, was admitted into the hospital on December 2, 1897. The child had previously been suffering for seven days from feverishness and cough. On admission the temperature was 103.6°, pulse 180 and respirations 56 per minute. The bowels were relaxed—motions a green color and very offensive. Patient was troubled with

^{*} Presented to the Section of General Medicine and Pathology.--Journal of the British Homeopathic Society.

a frequent short cough. There was impaired resonance over the left scapula, and sharp crepitant râles all over the chest. The temperature assumed an irregularly intermittent type—the morning temperature at times falling from three to six degrees—and the pulse-respiration ratio varied from 1 to 2 to 1 to 3, instead of 1 to 4, which is the normal.

At the end of the first week there was evidence of well-marked consolidation of the apex of the left lung; from this time there was a continuous irregular fall in the temperature, until it reached the normal on the seventeenth day; the diarrhoea then ceased. From the time the temperature began to subside the consolidation commenced to clear, and this process was completed four days after the temperature reached normal.

See temperature chart No. 1.

Diagnosis.

With regard to the diagnosis of broncho-pneumonia the greatest difficulty is experienced in distinguishing between the lobar and lobular forms of pneumonia, and especially that form of lobular pneumonia in which the greater portion of a lobe is consolidated and known by the name of pseudo-lobar pneumonia, or the aggregate lobular pneumonia.

Croupous or lobar pneumonia generally occurs in children above 4 years of age who have been in a previously good state of health. The attack begins suddenly with one or more of the following symptoms: Vomiting, convulsions, headache, delirium, rigors being usually absent. The temperature rises rapidly, often to 104° or 105° within twenty-four hours. The temperature remains tolerably regular, with morning remissions of from one to two degrees, and in the course of from five to seven days terminates in crisis. The pulse-respiration ratio is about 1 to 21. Frequently there is a herpetic eruption on the lips. Often one lung only is involved, and the upper lobe is most frequently affected. There is an early appearance of dulness to percussion; usually bronchial breathing and bronchophony and increased vocal vibrations are well marked. Fine crepitation is heard during the period of engorgement and returns during the process of resolution. See temperature chart No. 2.

Broncho-pneumonia generally occurs in children under the

age of 5 years. The illness begins insidiously, and is usually preceded by measles, bronchitis, whooping cough or diph-

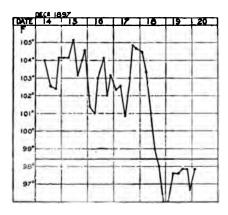


CHART No. 2.

theria. The temperature rises slowly, and is irregularly intermittent, with morning remissions varying from three to five degrees. It is indefinite in its duration, frequently lasting three weeks, and often much longer, and is not rarely followed by relapse or permanent impairment of the lungs; termination takes place by lysis. See temperature chart No. 3.

The pulse varies from 120 to 200. Respiration is thoracic in type, and often as frequent as 60 to 70 per minute. The pulse-respiration ratio is 1 to 2, or even 1 to 1½. There is frequently diarrhæa and vomiting. The bronchial secretion is never expectorated in children under the age of 5 years. Is it not probable that the diarrhæa, from which so many of these children suffer, is caused by swallowing the mucus? Both lungs are generally involved. Râles of all descriptions are present; dulness to percussion is late in its appearance. Breath sounds are weak or absent, or of a blowing character; seldom bronchial breathing is heard.

Bronchitis.

There is usually not much difficulty in diagnosing bronchitis affecting the smaller tubes, for here there is no evidence of consolidation of the lungs. The temperature seldom rises above 102°, and the pulse and respirations only rise in the same ratio. Every variety of pulmonary râle may be heard excepting the fine crepitation, which is pathognomonic of croupous pneumonia.

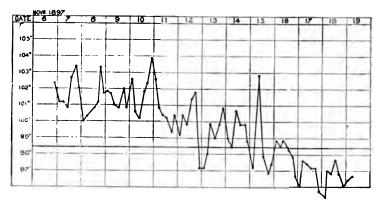


CHART No. 3.

Bronchitis affecting the smallest bronchial tubes—that is, the bronchioles—only, and which used to be known by the name of capillary bronchitis, cannot be diagnosed with certainty, and has never been found post-mortem. It is always followed by extension of the inflammation to the alveolar cells, and therefore should be considered as the first stage of broncho-pneumonia.

Prognosis.

The following are the more important signs and symptoms affecting an unfavorable prognosis:

- (1) The age of the patient. The mortality is very much higher among children during the first two years of life.
- (2) Cases which are secondary to diphtheria, tuberculosis, meningitis and whooping cough.
 - (3) Where extensive areas of the lungs are affected.
 - (4) Accompaniment of diarrheea and vomiting.
- (5) When the respirations are more than fifty to the minute.
- (6) Much alteration in the pulse-respiration ratio. When it reaches 1 to 13 the case almost always proves fatal.

- (7) When the child is unable to take a good drink at the bottle, being compelled to loose hold to get breath.
 - (8) When the child ceases to cry and cough.
- (9) The presence of an expiratory "grunting" sound during expiration.
- (10) A sudden drop of the temperature accompanied by dyspnœa is frequently followed by death.
- (11) A sudden considerable rise in temperature often takes place just before death, sometimes going as high as 108°. **Mortalitu.**

Under allopathic treatment the mortality of bronchopneumonia is generally conceded to be from 40 to 50 per cent.

Goodhart quotes forty-five cases, of which twenty-five proved fatal.

Jurgensen says that from a half to two-thirds of cases under his observation terminated fatally.

Meinsen lost 50 per cent of his cases under 1 year, 40 per cent under 3 years, 25 per cent over 3 years.

Bouchut lost thirty-three out of fifty-five cases under 2 years.

Gordon Morrill collected 325 cases from various sources, all of which were under the age of 10 years; he found that the mortality reached 48 per cent.

Treatment.

Aconite is only useful during the early stage of the disease, and should be stopped as soon as there is evidence of consolidation.

Antimonium tart. is our sheet anchor, especially when there is much rattling of mucus; it should always be given in trituration, as the solution readily decomposes.

Phosphorus is indicated when the lungs are in a drier state, and there is much consolidation.

Iodide of arsenic is of special value when the bronchopneumonia is of influenzal origin, and is always invaluable when the temperature drops to normal, in order to promote resolution, and is especially useful when there is diarrhœa and other digestive disturbance.

I have tabulated all the cases of pneumonia occurring in children under the age of 5 years which have been admitted into the hospital during the time I have held the appointment of house physician.

I would like to take this opportunity of thanking the members of the medical staff for their courtesy in allowing me to make use of the notes of the patients treated in the wards. The table is drawn up in such form that the prominent features of each case can at once be seen.

The cases under consideration are seventeen in number. The first fourteen of them were cases of broncho-pneumonia, all of which recovered. The last three were of the croupous form. No 15 made a good recovery. No. 16 died on the eighth day, death being preceded by convulsions, and a temperature of 108.4°. On post-mortem examination it was found that double croupous pneumonia was present, and that both lungs contained tuberculous deposits. No. 17 was admitted in a moribund condition, and only lived five hours after admission.

The table is of interest, first of all, as showing that none of the patients was above the age of 4 years, and more than half were not more than 2 years old—that is, the age which is attended by far the greatest mortality.

The duration of the fever lasted from three up to eighteen days, and in the case of No. 3 lasted for twenty-two days, but this was no doubt in part owing to the complication of catarrhal laryngitis and whooping cough.

In five cases the temperature reached 105°.

Gordon Morrill quotes two cases in which the temperature reached the phenomenal degree of 108° before the fatal termination; it will be seen that No. 16 reached nearly half a degree above that record.

The rate of the pulse varied from 140 to 184, and in four of the cases reached 180. The respiration numbered from 40 up to 88, and in one case, which recovered, was as rapid as 100 per minute. The pulse-respiration ratio varied from 1 to 1½ to 1 to 3, and in No. 8 was as low as 1 to 1 1-5.

In most of the cases there was considerable morning remission of temperature, and in the case of No. 4 it fell as many as 7°. When the crisis took place in No. 15 the temperature dropped 84° within twenty-four hours.

Both lungs were affected in nearly all cases.

Termination of the fever took place by lysis in all the cases of broncho-pneumonia. The time taken for resolution after the fall of the temperature varied from three up to sixteen days. Cure took place in all with the exception of two of the croupous form, one of which was admitted in a moribund condition, and the other was of a tuberculous nature. In no case was there a relapse.

No. 3 was complicated with catarrhal laryngitis and whooping cough, and this, no doubt, in a measure accounted for the prolonged duration of the fever.

In No. 5, although the temperature did not go above 100.6°, and the duration was only three days, yet there was very great dyspnœa, accompanied by retraction of the chest.

Nos. 3 and 14 were complicated with whooping cough. In Nos. 10 and 16 convulsions were present.

The benefit derived from homoeopathic treatment of broncho-pneumonia is most strikingly shown, first, by the great reduction of the mortality. As mentioned above, most authors place the death rate somewhere between 40 and 50 per cent, and here are fourteen consecutive cases without a single fatal termination.

Secondly, I think it is a very fair inference that the course of the disease is very materially shortened. Under the old school treatment the average duration of the disease is estimated to be from two to three weeks, and frequently much longer.

Reference to the tabulated report will show that only in one case did the duration reach the three weeks, and that the average of the fourteen cases would work out to be ten days.

Thirdly, under allopathic treatment relapses and recurrent relapses are of common occurrence, and not infrequently the lungs are permanently damaged; whereas, the fourteen cases which received homœopathic treatment recovered without a single relapse, and there was no reason to suppose that in any case the lungs had received any permanent damage.

Fourthly, another advantage of the homœopathic treatment is that after the subsidence of the fever resolution of the inflammatory products is speedily effected, and in no case

Summary of all Patients under age of 5 years admitted into the London Homeopathic Hospital (from October 10th. 1897, to February 24th, 1898) suffering from Pneumonia.

BRONCHO-PNEUMONIA.

Tres traent.	Ac., Phosph., Ars. Iod. Ac., Phosph., Ars. Iod. Ac., Spongia., Phosph., Art. Tart., Ac., Ant. Tart., Ver. Virid, Ars. Iod. Ac., Ant. Tart., Ars. Iod. Ac., Ant. Tart., Phosph., Ars. Iod. Ac., Ant. Tart., Phosph., Ars. Iod. Ac., Ant. Tart., Phosph., Ars. Iod. Ac., Ant. Tart., Phosph., Ars. Iod. Ac., Ant. Tart., Phosph., Ars. Iod. Ac., Bry., Drosers., Ant. Tart., Ars.	
etc.		_
Complication, etc.	Catarrhal Laryngitis and Pettussis Diarrhora Great drypuœa Diarrhora cheyne Stokes Resp. Convulsions	
Relapse.	None	_
RealL	Cured	_
Time of Resolu- tion after fall of Temp. in days.	200 40220000000000000000000000000000000	_
Crivia or Lysis.	Lysis	
One or both Lungs myolyed,		_
Greatest remis-	అ ంగ్లో ⊱జాలంజూళ్ళుంది. ఆంగ్లా	_
Highest Pulse. Resp. Ratio.	2	
Highest Resp.	0.528	_
Highest Pulse.	150 1150 1150 1150 1150 1150 1150 1150	_
Highest Temp.	1023-8 1065-4 1065-4 1001-6 1067-8 1047-8 1047-8 1017-8 1017-8 1017-8 1017-8	
Poration of Fever in days.	6 11 16 16 18 18 18 10 10	_
Age in years.	88 12 12 12 12 12 12 12 12 12 12 12 12 12	
Name.	Young, A. Cook, M. Syratt, W. Collins, N. Collins, N. Epps, N. Fronce, E. Frankel, E. Randall, L. Kirkhan, H. Kirkhan, H. Kirkhan, H. Bradley, E. Cato, R. Bradley, E. Cato, R. Bushell, M.	_
No.	11 12 12 13 14 15 15 15 15 15 15 15 15 15 15 15 15 15	

Treatment.	Ac., Phosph., Ars. Iod.
Complication, etc.	Tuberculosis, Convul- sions
Rolapse.	None
Result.	Cured Died
Time of Resolu- tion siter fall of Temp. in days.	bours.
Crisis or Lysis.	Crisis
One or both bayloved beyloved	C1 C1 C2
Greate-t Remis- sion in 24 hours.	0 . L
Highest Pulse.	168 56 1-21 8 180 72 1.2 4 4 4 4 4 4 4 4 4
Highest?Resp.	56 72 rbund
Highest Pulse.	168 180
Highest Temp.	105°-2 108°-4 dmitted in
Te not faring Byah in 1-797	ပ∞ ▼
Age in years.	101
Naume	Ashton, H. Barrett, E. Kineally, S

CROUPOUS PNEUMONIA.

was the delay more than sixteen days, and in the majority of the instances it was completed within the week.

On examination of the hospital records for the last five years I find that forty-nine children, up to the age of 5 years, were admitted for broncho-pneumonia, and that out of these there were only six deaths.

Four of the fatal cases were admitted in a moribund condition, and two were complicated with croup.

The mortality for the five years is 12 per cent. Discussion.

Dr. Hughes said he was recently summoned to attend a child for measles, and discovered that its temperature was nearly 105°. Next day broncho-pneumonia declared itself. He gave phosphorus as high as the sixth dilution, a drop every two hours, and the effect was most happy. The inflammation rapidly subsided, and in three or four days all danger and anxiety from that source was over. He had always maintained that phosphorus should be given in preference to almost any medicine in acute inflammation of the chest in young children. He did not intend to depreciate antimony, but only to speak of medicines of that type as better suited to cases of bronchitis in children than such as ipecacuanha and bryonia, which only touched the tubes and did not follow the morbid process into the air-cells.

Dr. Blackley suggested that the provings of ipecacuanha upon animals led one to suppose that ipecacuanha was not only a simile but a simillimum for broncho-pneumonia, for it went quite as far in the direction of partial consolidation as anything one could possibly desire, and it was moreover accompanied by slight hæmoptysis in many cases. He thought antimonium tartaricum was more helpful than phosphorus. He would suggest that phosphorus was more akin to the croupous form of pneumonia. The pathological condition excited by phosphorus was distinctly of the croupous kind, and that excited by ipecacuanha and antimonium tartaricum was rather of the lobular variety. Recently he had had a good deal of experience in the matter of broncho-pneumonia following influenza, and thought there was a medicine which was superior, to the whole lot put together, and was practically a specific,

to-wit, iodide of arsenic. Where influenza was at the bottom of lobular pneumonia he thought it a waste of time to give other medicines. He used it in the third decimal trituration.

Dr. Nankivel thought that in the case of adults bronchopneumonia was recognized as catarrhal pneumonia. There were hundreds of cases of catarrhal pneumonia among the working classes which were never treated at all during the acute stages, and they finally developed into phthisis. He suspected in the long run it was quite as fatal in adults as in children. He agreed as to the value of antimony if one got the cases early. Ipecacuanha would come in where the gastric disturbance was less well marked, and iodide of arsenic was most useful in subacute and chronic stages. The experience of himself and of his colleagues maintained this as a solid therapeutic fact.

Dr. Stonham thought that the use of bryonia on the third day of an attack of measles prevented an attack of bronchopneumonia in children. Of course, it was difficult to prove a negative, but, at any rate, the patients so treated, never had the disease. He thought broncho-pneumonia following influenza was rather different in type. It was hardly pneumonia, but was more of an inflammatory cedema.

Mr. Wright said when he was house surgeon they had a fatal case of broncho-pneumonia in which the temperature rose to 109°. A well-authenticated case of temperature of 108.5° occurred in a child aged 10 months. A bath of 100° F. brought the temperature down to 101°. The temperature rose again to 104°, and later on to 105°, but a bath of 100° again brought the temperature down to normal, and it remained there until recovery. Antimonium tartaricum was his favorite remedy. In the case of old people who had catarrhal pneumonia he had used carbonate of ammonia in the dose of a third of a grain, and found it one of the best stimulants. He had not to use much in the way of alcoholic stimulants when that was kept up. Ipecacuanha never used to succeed so well as antimonium tartaricum. Vomiting was nearly always present in cases in which ipecacuanha was used as a proving, yet one rarely came across cases of broncho-pneumonia in which vomiting was a

symptom. He thought that rather put it out of court as being a simillimum.

Dr. Jones said he had recently had two cases of bronchopneumonia in children, both of which followed measles. In the first the temperature would not go down for many days, and when it did, under arsenic and iodide of potassium, it suddenly went up again to 104°. At that time Dr. Blackley saw the patient and suggested iodide of arsenic, and from that moment everything went well. In another case he had given bryonia and iodide of arsenic in alternation with good results.

Dr. MacNish had derived brilliant results in the early stage of the disease from veratrum viride, 1x.

Mr. Johnstone said he had recently three cases in children of whooping cough, complicated with measles and bronchopneumonia. He had adopted with good effect the medicines used by Mr. Watkins. He wished to ask whether Mr. Watkins gave the antimonium tartaricum, or the arsenicum, first.

Mr. Watkins said he used the antimonium tartaricum first. Mr. Johnstone said that probably arsenicum had very much the same action in broncho-pneumonia as it had in tuberculous conditions, viz., that of tending to resolve the hyperplasia of the tissues and consolidation of lung.

Mr. Watkins, in reply, said no local applications had been used with the exception of the Gamgee wool jacket.



CLINICAL NOTES ON ENDOMETRITIS, CHIEFLY THE SENILE FORM.

BY WILLIAM CASH REED, M.D.

Though I have not, perhaps, chosen for my paper a great theme, it is an every-day one for each of us, and thus its very commonness lends it dignity. Moreover, it is the source of great suffering to countless numbers of the other sex, and thus, again, it demands at our hands a careful and critical study.

"Inflammation of the uterus," so-called, is so protean in its signs and symptoms, and is so governed, as regards these, by the "personal equation" of the patient, that it were hopeless to attempt, in the space at my disposal, to consider anything more than a brief clinical picture of a few cases which have recently come before me.

I shall not pretend, nor do I desire, to offer any initial schema of symptoms, however useful such may be in its way and in its proper place, for the patients here considered are not lay figures ticketed and labeled for our edification. They are, or at least they pretend to be, "portraits from life," and as such must furnish their own inferences and point their own moral.

And now, having completed my apologia, I put before you the following cases:

Case I.—Miss X., aged 68, consulted me last summer for a constant sensation of "bearing down" and "dragging" in the groin and left ovarian region, which she significantly observed "affected the throat." There is also much pain in the sacrum, and, worst of all, she suffers from a profuse and very offensive leucorrhæa, now bloody, now yellow, but always glutinous and glairy. This elderly lady had all her life been more or less an invalid, and but for an indomitable will and perseverance must have succumbed years ago to the dominating power of a many-sided malady, which would have swamped the individuality of any score of mediocre women, and would have left her, but for these saving qualities, a mildly protesting, fatuous "sofa invalid," the despair of friends, and for the doctor a doubtfully

desirable, if lucrative, patient. But this lady was destined for better things—to be a stimulant to the faint-hearted and a cold douche to the hysterical.

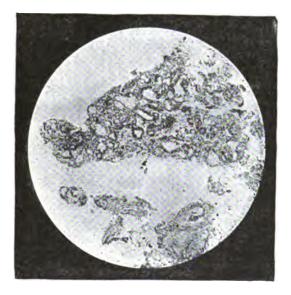
She has inherited, along with other family heirlooms, the gouty diathesis and a lymphatic tendency. She has suffered from asthma for ten years, and from chronic bronchitis for much longer, and has now extensive emphysema of the lungs, with a barrel-shaped chest, and there is always more or less basic stasis present. Her sleep is very indifferent and her extremities cold.

This patient has for many years been under the care of one of the most distinguished medical men of the day, and before that under one of the most able and best known provincial surgeons in the heyday of his fame.

The condition, then, on arrival was not one which promised a very substantial framework for successful decoration, either on the lines of surgical interference, or the gentler ones of drug selection. There was, however, one ray of light on this pathological picture, and that was that the urine was free from albumen.

But to make a diagnosis as a gynæcologist was the first thing to be done, and on examination I found a bulky, soft, easily bleeding uterus, pendent low in a capacious vagina, the mucous membrane of which was of a dark, venous hue. The sound passed in a normal direction for 31 inches, with an arrest at the internal os, and considerable pain there, and brought away on its withdrawal not a little blood. The case thus looked grave, and I told the friends so, and but for one point in connection with the leucorrhoea, above referred to, should have said exceedingly grave. This was, that the bad odor connected with this discharge was not a new development in the case, but had been existent for many years. The only treatment which appeared to me to hold out the least likelihood of permanent benefit was a thorough curettage of the uterine cavity, and I had the satisfaction of a confirmation of this view by Dr. Burford, who traveled from London to see the case. Under an anæsthetic administered by Dr. Midgley Cash, of Torquay, and with Dr. Burford's valuable assistance, I dilated the uterus to its fullest possible extent on July 24, and

curetted the endometrium in the most thorough manner. Care was very necessary, for, as in the typical senile uterus, its walls were soft. Pure carbolic acid was applied to the interior of the denuded organ, and the fragments removed by the curette preserved for examination. The patient was a good deal collapsed, but by and by rallied, and on the third day I removed the intra-uterine gauze. Convalescence, so far as the operation was concerned, was rapid and uneventful, but in view of the pre-existing troubles, vomiting, bronchitis and diarrhœa, kept her ill for a long time. This, however, was anticipated, though trying enough in the reality.



Micro-photograph illustrating Case I.

The further history of the case I shall dispose of in a few words, but its pathology demands special attention.

The patient ultimately returned to her home in Devonshire with a uterus normal in size, with a minimum of "bearing down" and no leucorrhœa. The involution was assisted by the li. extr. of ergot. The chief comfort, perhaps, to the patient consisted in there being now no necessity for a pessary, which for a great number of years she had not been able to do without

From a letter received three days since I learn that the patient remains well locally, in spite of a severe attack of "influenza" just passed through.

As to the pathology, I have here photographs of the slides furnished by Mr. Johnstone, and cannot do better than quete his able report in this connection:

"The arrangement of the epithelium is certainly not normal. I believe there is a papillomatous condition of the mucous membrane, with a heaping up of epithelium in places. Also, occasionally we can see spots suggestive of infiltration of the epithelium. On the whole, I am inclined to think that if the condition is not actually malignant, there is at least a malignant tendency."

In the "British Medical Journal" of May 19, Dr. Halliday Croom is reported to have said, "Senile uterine catarrh was not among the prodromata of malignant disease; the two conditions were quite distinct. Dr. Croom had never seen a case of the simple condition later become one of cancer."

I venture to think that the case I have just described amounts to proof positive of the opposite conclusion.

Case II.—About a year ago I was consulted by a lady, aged 36, about to be married, on account of metrorrhagia. She is anomic and has an anxious expression. The general health is very good, and there is nothing special to remark as regards the family history, except that there is a tendency to gout. One point, however, is noteworthy and curious; she is the third in a family of five, and all, with the exception of the patient, are deaf, one very "much" so, from chronic middle ear disease.

I ascertained that the "periods" had always been very profuse, usually necessitating twenty changes. Further, the type of metrorrhagia described was that in which there is, broadly speaking, only about one week in four during which it can be said that the patient is absolutely free. The interval, with this exception, between the "periods" is filled up by a more or less constant sanguineous drain, and especially that week in the cycle which may be looked upon in point of time as the one prior to the normal recurrence of the flow. The drain referred to is not of the "prune juice" type, but is best described as "florid." There is no leucorrhæa. In view of the foregoing,

I employed the following: Crocus, china, chin. sulph. and pulsatilla, but with not the slightest benefit, and I began to suspect there must be a local and tangible cause to account for the persistent condition.

The patient was therefore anæsthetised, and the diagnosis proved to be but the work of a moment. The examining finger came immediately upon a patulous os, situated in the centre of an area of roughness about the size of a sixpence; all the characteristics, in fact, of a simple erosion. Voila tout! There was no true ectropion, but a desquamation of the superficial layers of pavement epithelium about the os, due probably to the acridity of a discharge, relatively slight in amount, from an endocervicitis of long standing.

The treatment consisted of ichthyol-glycerine locally, together with the hot douche, and the administration of platina, and later on phosphate of strychnia.

The patient made a steady recovery, and is, I think, in such a state of health that utero-gestation, should it occur in the natural order of things, need not be feared, either with regard to premature evacuation of the uterus, or undue trouble during the puerperium. In searching for an explanation of this case of endometritis in the virginal uterus, one is confronted with a difficult question at the outset. Why should an organ in the economy which, except for the periods of menstrual activity, occupies the place so well described by Dr. Burford of a "resting-spore," take on thus an aberrant functionising, and setting up anæmia as a direct result, perpetuate through it the vicious cycle of morbid changes shown in this case? What is essentially the first cause in the chain of events?

The patient was otherwise in the very best of health, and there was no evidence of congestion by faulty clothing; quite otherwise, nor yet as the result of a so-called "chill" at the "period." Nor was there evidence either of the introduction of microbes from without. I am inclined to hark back far in this case, and to find the first cause in the gouty diathesis previously referred to, and to regard it as that morbid entity which found its sphere of action on the mucous membrane of the middle ear, in all her brothers and her sister, but in the

case of our patient the uterine mucosa was selected to bear the brunt of the impact.

Dr. Cash Reed then threw upon the lantern screen a slide showing leucocytosis, probably amounting to pus, from a case of non-gonorrheal inflammation of the introitus vaginæ, in a virgin aged 24. Cause unknown; severe and somewhat intractable to treat. A sister of patient has just died of phthisis, but there are no tubercle bacilli to be found in this case. It may be regarded as illustrating the initial stage of a non-specific peripheral inflammation of the general tract, which, unchecked, would ultimately reach the peritoneal end of the same tract, resulting in well-known lesions.

He next exhibited a slide taken from a case of hæmorrhagic endocervicitis in a patient aged 52. "The specimens showed diplococci. The cultivation proved them to be staphylococcus albus."

The symptoms were essentially pain in "bottom of back," accompanied by a colored discharge. The "period" only ceased five months ago, and ever since she has had this discharge.

The next slide showed hypertrophic endometritis (glandular form). There was a clinical history in this case sufficiently suggestive of a "missed abortion" to warrant careful investigation. After curetting the enlarged uterus and submitting specimen to the Clinical Research Association, he received the following report: "The uterine curettings consist of hypertrophic endometritis, and there is no placental tissue present in portions examined."

The next case was one of columnar-celled carcinoma. The specimen was obtained from a widow, aged 50, who complained of a "drain," and strongly resented the suggestion that it might be a matter of importance. Examination revealed a nodular and friable cervix, practically conclusive of carcinoma.

A portion removed with the finger nail was submitted to the Clinical Research Association, which sent the following report: "The tissue from the cervix uteri is infiltrated with a columnar-celled carcinoma—much of the growth is necrotic."

Dr. Madden said if a simple hypertrophic condition of the

uterus with catarrh in old women was liable to turn into malignancy, was it not desirable, when it had begun to change, to remove the whole of the affected organ? It was surely beyond dispute that to remove simply the diseased portion of any organ affected with malignant disease was merely a temporary remedy, and that the disease was bound to return so long as the organ in which the disease had started remained in the body. It would certainly lead one to be more ready to propose operative interference in the milder cases, which had not begun to show a malignant tendency, to know that there was a tendency to take on the malignant change. He thought that both Mr. Johnstone's slides and his report would lead rather to a pious suspicion than to any certainty as to the presence of malignity. He should like to hear from Dr. Reed whether his case was not one rather of continued activity of the uterus than of renewed activity; and whether he could really say there was malignancy present rather than a mere suspicion of it.

Dr. Hughes asked how long they must wait for the development of malignancy in cases in which the uterus has taken on morbid activity after the climacteric. How long were they to wait before they regarded as an evil omen any recurrence of the monthly loss? He observed that most cases developed malignant disease not long after. He now had a patient, aged 85, who had a recurrence about twenty years ago, and he was very anxious at the time lest it should have a fatal meaning for her. He gave her some vinca minor, which his friend Dr. Henry Madden used to swear by in such cases, and the flow soon ceased. He had had to attend the lady lately for tic douloureux, but she had had no uterine trouble since.

Dr. Neatby said that the first point in the paper which he would mention was that some of the patients had many other lesions besides the local one, and that Dr. Cash Reed's general treatment, combined with the local treatment, had been exceptionally successful. He thought that they ought all to take courage in their homœopathic treatment, becauses cases like those in question had often baffled their best efforts. When they heard of definite results from homœopathic treatment combined with careful local measures, they should take fresh

heart of grace. He would like, in passing, to confirm what had been said about the danger of the recrudescence of activity in a senile uterus. He thought that they all recognized this danger sufficiently nowadays. There was no doubt that it was a totally different thing when they got suspicious cases. even evidenced by the microscope, when this occurred before the menopause. He thought that they were all learning to look with some suspicion on the microscope. It was extremely useful, and they could not possibly do without it, but they did not know enough about it and enough about pathological conditions to draw absolutely certain inferences from it. There were two or three cases in his mind in which competent observers had reported that there was commencing malignant disease of the endometrium, and he had, on the strength of that, recommended prompt removal of the uterus. Naturally, patients liked to have a say in the question themselves, and in more instances than one they had declined the suggestion he had made, and had "lived happy ever after." He had therefore come to the conclusion that they must be very careful in arriving at a certain conclusion of that kind, and he thought that they could say that a little thorough curettage of the uterus was a very definite help in cases like this. No doubt if the process was to go on unchecked, and that the cells were to spread and infiltrate the tissues, recrudescence would occur, and malignant disease would develop; but he believed very strongly in the good results of a very thorough curettage, combined with anti-carcinomatous remedies, if he might use the expression.

Dr. Cash Reed, in replying, said that Dr. Madden had asked why, after a strong suspicion of malignancy, the whole organ was not removed. He could not say what would be the best practice in other cases, but in the case which he had mentioned, he was perfectly certain that the patient would not have stood the operation, from the fact that she was exceedingly ill otherwise. She had chronic basic stasis, together with chronic bronchitis and other ailments to which he had referred. With reference to the question whether, under similar circumstances, given a healthy individual, it would be wise to amputate the uterus of a woman aged 70, he could only say that

he endeavored to ascertain whether there was anything definite and tangible by giving the patient an anæsthetic, and by a very careful exploration of the pelvis he could find no lump of any kind whatever, but simply the heavy large, soft uterus which he had referred to; so that, even if the patient had been strong, he should not have felt justified in recommending the more radical measure. Whether this case could be looked upon as one in which natural changes had taken place, he could not say, i. e., whether there had been a proper arrest and then a recrudescence of the symptoms after the "period" had once ceased, he did not know. He could only say what he judged to be the case when he saw her. He saw the patient about three months ago, which was three months after the operation, and he thought that there might be a strong malignant tendency in the case. He explored the pelvis again without an anæsthetic and he was quite certain that he felt with the examining finger a hardish, irregular nodule, which he had never felt before. He had not had the opportunity of seeing the lady since, but the disease appeared to have been in abevance. He could not say whether it would start into activity, but it would appear to be probable. His point was to try to prove that the two conditions of senile endometritis and malignant disease had a very close affinity, and the one had at least a tendency to run into the other eventually.

Institute Etchings.

O. iginal communications to the Bureau of Pedology, June, 1898, stenographically reported for this Journal.

MALNUTRITION IN CHILDHOOD.

DR. B. H. OGDEN.—Malnutrition is not confined in its effect to those seen in childhood. There are those which go on into adult life. So we have a larger problem on our hands than we might prefer to think.

How shall we combat the symptoms? Whenever we confront a case of malnutrition we have a difficult problem before

us, and we must approach it in the spirit of the detective. These little ones tell us nothing. The mothers are even inactive and our success often depends upon our treatment of these cases. I know of no class of troubles in which attention is so exacting as in the diseases of children. In the majority of cases we do not have a trained nurse. We must depend upon the mother, whose lack of training is a cause of inefficiency. It is not enough to give them directions, but you must see that the details are carried out. It is not enough to ask the mother of the character of the stool. You must examine it yourself. You must see the food and see if her description of it is correct. It is important that the mother be taught the necessity of weighing the child every two or three weeks, and noting its continued growth. Many cases of malnutrition have been far advanced before the mother is aware it is sick. The increase of weight is an important fact. If a child does not seem well, but is gaining in weight, I have not the anxiety that I have if he seems bright, but is not gaining weight.

MARASMUS.

DR. W. E. LEONARD.—The term "Marasmus," to my mind, covers a multitude of sins. It is to the child what the term "heart failure" is to adults. It means the same thing as "I don't know." It means the child starved to death, and we don't know hardly why.

An exhibition of the proper food is an exhibition of the proper remedies, and in many of the calcarea salts we find a great remedy in the nourishment of the child. The occasional weighing of the child, even though they may not think it sick is, I think, one of the most important diagnostic symptoms. The symptoms of pallor, lack of appetite and the whole line of symptoms may be present for weeks or months without realizing there is anything going on.

INFANT FEEDING.

DR. L. I. DANFORTH.—With regard to the effect of mother's milk during the first weeks of infantile life, it is assumed that the child is getting just what it requires, but this is not absolutely true. We all know that mother's milk will all vary exceedingly in its conditions, constituents, etc.

During the first two or three weeks of infantile life the baby is usually suffering from colic, and passes a great deal of air from the bowels. If you will analyze the milk, you will find that in the mother's milk the fats are low and the proteids are in excess. If the woman is sent into the open air the proteids will fall and the fats increase, and the baby get over its colic, and will need no other medicine.

I think we should weigh the child once or twice a week. If it gains four ounces it is doing well. If it is gaining two ounces it is doing well. Later on you may find the baby does not grow. The probability is that the proteids are low. The baby is not getting bone-making and blood-making milk.

Now a word with regard to the effect on the child's digestion of insufficient or excessive proteids. If the child is not getting proteids enough it will have colic, and often too many stools, and will not increase in weight. If it is getting too much proteids it will vomit sour milk. Dr. Cobb said that the proteids should be supplied to the child during the first year of life in milk alone. Now, I think a child will sometimes require more proteids than it can digest when given in milk. If we cut the supply of milk down and supply it in weak beef juice the child will often grow.

MOTHER'S MILK.

DR. C. J. LUYTIES.—I am very much interested in this subject of infant foods, because of my connection with a number of institutions where infants are treated. I believe the causes are not so much those of the blood as that the blood's condition is due to the inanition or lack of assimilation on the part of the child, and what causes this lack of assimilation is what we want to consider. I believe that is due to a variety of causes. One is improper food, another is proper food in improper quantities, and given at improper times. As to the improper food, we all realize what it is. It is that which will bring about a diseased condition. With regard to proper food given in improper quantities, we all know that the volume of food is increased one-third by the process of digestion. The stomach needs to be empty for a time to be prepared for the subsequent meal. I believe this an improper time of feeding. when the child is not in a condition to receive food at all. If the child is restless all night the food should be diminished in quantity. And I believe that frequently the digestion is interfered with by substances in the intestinal cavity.

TREATMENT OF ANEMIA.

DR. CHARLES GATCHELL.—I will make a suggestion in the matter of the treatment of cases of anemia, chlorosis and malnutrition generally. It is of special value in the treatment of so-called "scrofulous" children. I refer to the sun bath. It is a very easy matter to improvise a home solarium for the purpose. Place a table before a window which admits the direct rays of the sun. On the table spread a folded comfort, covered by a sheet. On this place the child, divested of all clothing. Let it be for an indefinite length of time. The two precautions to be observed are to protect the child's eyes from the glare of the light, and to guard the skin from sunburn. A bath of an hour's duration is not too long, but there is no limit to the time, so long as there is no danger of sunburn. This latter is not apt to occur. It can be guarded against by giving the sun bath early in the day, or late in the afternoon. It adds to the child's comfort if the skin is gently stroked by the hand of an attendant. Don't forget the protection of the eyes. From the treatment described I have had very beneficial results.

THE CHILD.

DR. T. C. DUNCAN.—I have listened for one thing that I have not heard. And that is the child. The diagnosis from the child's standpoint. All children are not the same. They are supposed to weigh seven pounds at birth. If they are a great deal smaller, then you have marasmus from the beginning, and what can you expect? As old Dr. Shipman said, after he had established the Foundlings' Home, "I thought I knew all about children, but when I had a lot of foundlings I found I knew nothing."

There are constitutional defects—organs not developed. Take the one organ of digestion. You sometimes find the stomach as big as your two firsts and the liver not as big as your hand.

There are a few expedients that I find good to adopt very early in child life. The first few hours of child life the skin

undergoes almost a positive inflammation, and sometimes the mucous membrane is involved, giving us a condition that if we feed then we have a sick child; and hence I enjoin the nurse and mother to let the child alone until the physiological forces have gone along and given the system a thorough opportunity to get in proper condition.

WATER IN PEDOLOGY.

DR. BOUTIN.—Frequently these cases are caused, or if not caused, are prolonged, through a lack of water. I have asked with regard to a child a year old, Is the child thirsty? They never thought of such a thing. They never gave it any water mall its life. You should offer the child water every time it is fretful, a few hours after feeding. The trouble with many of them is that they want a little water. The food in the stomach may not be digested and they do not want milk, but simply water, and they are often given milk instead.

THE CHILD'S CLOTHES.

DR. C. H. COGSWELL.—If the child is not properly clothed the matter of feeding does not amount to much. I believe that the proper clothing of the child is one of the great considerations, without which food matters little. While clothing is necessary at all ages of life, it is especially necessary the first few months. More harm may come the first hour of the child's life than any later hour. This fact is of great importance.

DISEASE IN CHILDHOOD.

DR. N. B. DELAMATER.—How any person can treat diseases in childhood without a careful scrutiny of the urine, without learning what that would tell us by positive analysis, I cannot understand. It seems to me this is a central thought, the importance of the examination of the urine and what may be learned from that examination not only as to the diagnosis, but as to the elements in the treatment. It is a sure guide for prescribing diet, and a help in prescribing clothing. You will learn here that which will help you to know whether the child is too much or too little nourished; and just what particular element in nutrition is at fault.

Book Reviews.

Ophthalmic Diseases and Therapeutics. By A. B. Norton, M. D., New York City. With 90 Illustrations and 18 Chromo-Lithographic Figures. Second Edition, revised and enlarged. Price, cloth, \$5.00; half-morocco, \$6.00. By mail, 35 cents extra. Philadelphia: Boerickle & Tafel, 1898.

The new edition of Dr. Norton's valuable work upon Ophthalmic Diseases and Therapeutics is, in being much larger and more complete, an improvement upon the previous edition, but in other respects we do not think that there was much room for improvement, as the quick recognition of its merits by the profession showed, it having almost immediately upon its appearance having been made the text-book upon the subject in all but one of the homeopathic colleges attests. Over a hundred pages of new matter have been added, covering the following subjects: The examination of the eye; the use of the ophthalmoscope; the hygiene of the eye, a subject of practical value which has never before been written upon in any text book of the eye; refraction and accommodation. Special attention has been given in the present, as in the first, edition to the homeopathic treatment of diseases, the work being very rich in therapeutical suggestion, drawn from the author's wide experience. The illustrations are numerous and excellent, many new and original ones having been prepared for this edition, including six chromo-lithographs illustrating external diseases of the eye. In its total it is a complete and authoritative work upon ophthalmic diseases and therapeutics. and the best work upon the subject in any school.

THE OFFICE TREATMENT ()F HEMORRH()IDS, FISTULÆ, ETC., WITHOUT OPERATION. By Charles B. Kelsey, M.D., late Professor of Surgery at the New York Post-Graduate Medical School and Hospital, etc., etc. R. Pelton: New York, 1898.

This little work, which consists of three lectures delivered by the author at the New York Post-Graduate Medical School, is a protest against the far too prevalent idea of the medical profession that the only medical treatment of these affections is by operation. The author holds that a very large proportion of all cases of piles, fissures, superficial ulcers and pruritus, and a large proportion of abscesses and fistulæ, may be radically cured in one's office without ether, or confinement to bed. The book is interestingly and convincingly written, and contains much, particularly the second and third lectures, upon the relation between diseases of the rectum and other diseases in both sexes, but especially in women, and on the abuse of the operation of colostomy, which will be of interest to gynæcologists.

AN AMERICAN TEXT-BOOK OF GYNÆCOLOGY, Medical and Surgical. For Practitioners and Students. Edited by J. M. Baldy, M.D. Second Edition. Revised. Pp. 718: cloth, \$6.00; sheep, \$7.00. Philadelphia: W. B. Saunders, 1898. Sold by subscription.

The second edition of "An American Text-Book of Gynæcology" shows a very considerable revision of the first edition, much new material has been added, and some of the old eliminated and modified. Methods and details have been greatly modified and changed since the first edition was issued, some four years ago, and what was considered at that time, in many cases, the best method, has become obsolete. A large number of the illustrations of the previous edition have been replaced by new, many of them being in colors and half tone. We may remark, in passing, that the illustrations are numerous—341 in the text and 38 colored and half-tone plates—and good. The arrangement of the work has been considerably changed, and we think with advantage. The description of the preparation of each operation and of the after management of the patient has been placed in the chapters on Technique and After-Treatment, which avoids much repetition. The chapters on the Bladder, Urethra and Ureters have been extensively altered, and the portions relating to plastic work are practically new. Hysterectomy, both vaginal and abdominal, has been rewritten, and all descriptions of operative procedures have been carefully revised and fully illustrated. The book is thoroughly practical, as we should expect from the contributors—Drs. Henry T. Byford, J. M. Baldy, Edwin B. Craigin, J. H. Etheridge, William Goodell, Howard A. Kelly, Florian Krug, E. E. Montgomery, William R. Pryor and George M. Tuttle.

MEDICAL DISEASES OF INFANCY AND CHILD-HOOD. By Dawson Williams, M. D., Physician to East London Hospital for Children. In one 12mo. volume of 629 pages, with 18 illustrations. Cloth, \$2.50 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

This book, which is intended mainly as a handbook for young practitioners, is clearly and interestingly written, so that the attention of the reader is secured and kept throughout the work. It is given to but few medical authors to write as well and as clearly as Watson and Fothergill or Burnett of our own school; yet there is no reason why a medical book should be of a dry and repellant style, as so many of them are. In this respect this book has much to commend it. There is not much that is new to be said about the diseases of children, but the latest advances in pathology and treatment are fully set forth in this work, and while it is not a complete treatise upon the subject, it is sufficiently so as to form a practical and comprehensive handbook. The book embodies the experience of the author in the treatment of the diseases of infancy and childhood in the East London Hospital for Children, and the treatment recommended is that used in the institution.

AN AMERICAN TEXT-BOOK OF THE DISEASES OF CHILDREN. By American Teachers. Edited by Louis Starr, M D., Consulting Pædiatrist to the Maternity Hospital, Philadelphia; late Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc., and Thompson S. Westcott, M.D., Instructor in Diseases of Children, University of Pennsylvania, etc. Second Edition. Revised. Pp. 1244; cloth, \$7.00. Philadelphia: W. B. Saunders, 1898. Sold by subscription.

The "American Text-Book of the Diseases of Children," which practically covers the entire field of Pædiatrics, includes, in addition to the description of the usual diseases of children, special chapters on essential surgical subjects: Orthopædics; diseases of the eye, ear, nose and throat; diseases of the skin, and on the diet, hygiene and general management of children, and is the work of a number of the most prominent pædiatrists

of America, which has been carefully revised and rounded into a complete treatise upon the subject. The revision has been very thorough; new articles have been added; others have been emended, and a number have been entirely rewritten and brought down to date. Among the new articles are Modified Milk and Percentage Milk Mixtures, Lithæmia, and a section on Orthopædics; those rewritten are, Typhoid Fever, Rubeola, Chicken Pox, Tubercular Meningitis, Hydrocephalus and Scurvy; while more or less extensive revision has been made in the chapters on Infant Feeding, Measles, Diphtheria and Cretinism.

Maleria Medien.

Erigeron in Uterine Hemorrhage.

Dr. Lardinois: The flow is bright red, and increased on movement made by the patient.

Cuprum in Chorea.

Dr. Nunos: Muscular palpitations, piercing cries, contortions with laughter, melancholy, chorea in spells.

Lycopodium in Ovarian Pains.

Dr. McMichael, Hahn: Burning, stitching pains, extending from right to left ovarian region. Menses early or late, profuse or scanty. Sad and melancholy.

Nitric acid in Leucorrhea.

Dr. T. F. Allen: Leucorrhœa of stringy mucus, or green mucus or flesh colored or brown, acrid and offensive, or clear and acrid, excoriating the legs.

Sepia in Leucorrhea.

Dr. Ward: Discharge from the vagina is either decidedly yellow and purulent, or greenish, watery, fetid and acid. It is accompanied by oppression of breathing, weight in the abdomen, pains in the uterus, pruritus of the vagina and vulva, with excoriation. The third decimal trituration, in five-grain powders, four times in twenty-four hours.

Kreasote In Infantile Disease.

Kreasote is indicated in infants in whom the milk teeth turn black and fall off in small pieces.

Thuja in Fibroid.

Dr. Foulon: Thuja, persistently used, in a medium potency, will frequently cure fibroids of the uterine mucous membranes. **Kali chlor. in Glandular Swellings.**

Kali chlor., according to Schuessler, has proved very valuable in glandular swellings in strumous subjects, even after scarlet fever.

Nux moschata in Abortion.

Threatened abortion; hysterical females disposed to fainting; feels chilly and catches cold easily; fears she will abort; continued and obstinate flooding.

Carbolic acid in the Exanthemata.

Carbolic acid is very effective in counteracting the scarlatina poison, but does not seem to be of service in diphtheria. Used in the Ix dilution (freely) in water, carbolic acid will cure small-pox, i. e., get the eruption out, and carbolic acid will prevent pustulation and secondary fever.

Silicea in Rachitis.

Dr. Payne: In silica we have a clearly indicated remedy for rickets. It meets the bony lesion and the nervous condition. In th's remedy the complexion is pale, waxy, earthy; the baby sweats profusely about the head and feet, and the sweat is offensive. In the calcareas the sweat is sour.

Ipecac. in Pertussis.

Dr. W. A. Dewey: Convulsive cough, where the child stiffens out and becomes blue or pale, and loses its breath, great nausea and relief from vomiting are prominent indications for ipecac. A "gagging cough" is a good indication for the remedy. The discharge of mucus is copious and tenacious, and the patient is very weak after the attacks. Violent, shattering coughs following each other in quick succession, not permitting recovery of breath, indicate ipecac.

Pulsatilla in Backache.

As this symptom changes with every breath of the wind, and changes its position constantly, so do the symptoms which are characteristic of the drug. The pains are constantly flying from one portion of the body to another; the pains in the back

are fine, sticking pains; stitches in the small of the back; tensive, drawing pains in the loins; bruised pain in the back while lying in bed, causing her to walk about. The patient is usually better from gentle exercise.

Sulphur for Leucorrhea.

Dr. Searle, Hahn: Pruritus of vulva, with burning and stinging, with miliary eruption, worse from heat of bed. Prolapsus uteri, with aching across sacrum; constipation. Profuse yellow, corrosive leucorrhœa. Burning in vagina; is scarcely able to keep still.

Trillium after Labor.

Dr. Young, N. A. Jour. of Hom.: Woman, thirty. On first getting up after a normal labor had considerable bright red, bloody, uterine flow, with intense sacral backache, as if whole pelvis would separate in two halves, which was agg. by a tight bandage about hips. Also a sensation as if the pelvic contents would dropout through the vulva, better on standing, less when walking, and none when sitting; this is agg. by wearing a tight perineal support. Trillium, 3 doses, then S. L. About twelve hours after taking the remedy had severe numbness in entirearms and both legs and feet, half way to knee. Passed off gradually in course of next twenty-four hours, and within thirty-six hours all above given symptoms also.

Helonias in Enlargement of the Uterus.

In all simple organic diseases one of the greatest difficulties is to find out the organ-remedy that exactly fits the case. The provings made so far are generally insufficient. Rademacher, following Paracelsus, asserts that the organ-remedy cannot be determined before the cure is attempted, especially because the genius epidemicus morborum often comes into play in such cases. We meet with many cases of urinary troubles in which the primary ailment is an enlarged and too heavy uterus, which on that account has become dislocated; this is then followed by an irritation of the cervix of the bladder, with urging to urinate. In such cases helonias is frequently the right remedy; so in the case of a lady who suffered from a troublesome, frequent urging to urinate. This was accompanied with pains in the small of the back, the uterus was heavy, the urethra inflamed. The urine contained mucus. Helonias 3d in doses of six grains

soon removed all these symptoms, though the ailment had been of several years' standing.

Nux moschata in Uterine Prolapsus.

Hom. Envoy: Nux moschata cured a case of prolapsed uterus of many years' standing.

Kreasotum in Dentition.

Dr. Foulon, Clin. Reporter: For teething children, who are peevish and irritable, and who have excoriations about the anus or vulva, creasotum rather than chamomilla.

Calcarea in Hereditary Phthisis.

Dr. T. C. Duncan, Clin. Reporter: Calcum is a fat baby; always eating its fist; will eat bacon or butter. The glands are large. The child is fair but fat, a marble baby, and demands and enjoys much attention.

Macrotin for Uterine Headaches.

Macrotin, the active principle of cimicifuga rac., will relieve congestive headaches at the base of the brain, and where uterine congestion is also present, and perhaps some rheumatic symptoms besides. Ix to 3x trit.

Ustilago at the Menopause.

Dr. Ward, Med. Cent.: Ustilago has proved useful at the menopause where left ovarian neuralgia has been accompanied with habitual, profuse menstruation to be followed by brownish leucorrhœa. Especially suited to tall, slim women, with clear, white skin.

Picric acid in Neurasthenia.

Dr. Evans, Clinique: I have found this drug particularly useful in girls and young women, who, laboring under the prolonged strain of a multiplicity of studies, in combination with the anxiety and dread of failure in their approaching examination, develop all the signs of "breaking down," and bid fair to spend "commencement day" in bed. Such patients have no appetite, sleep lightly and lie awake and are so fatigued that when the school day is over they drop exhausted upon a lounge until they are roused by the knowledge that there are more lessons to memorize and piano practice to worry about. Languor and fatigue attend even upon a short walk, and twitchings of the muscles take place both when she is awake and asleep. A hysteric state presents itself, and will power is lack-

ing except under the stimulus of necessity. Headache, more or less constant, may be either frontal or occipital, and the menses are irregular. Such cases are usually considered to be subjects for the various salts of iron, and many are also fed on some combination of beef, wine and iron for weeks and weeks together, the slight benefit derived from their use in no way impairing a misplaced confidence in them.

These patients I have found by experience to be materially benefited by the use of picric acid, which covers the whole field of cellular changes in the blood and nerve centres. I do not mean that this drug is a specific for all such cases, for phos. acid, silica, nux vom., etc., etc., all have claims in this direction; neither will it be the all-sufficient remedy in these neurasthenias when other diseases are present; but in the uncomplicated cases I have just mentioned I am able in a large number of instances to afford relief by the use of this acid.

Lachesis in Menstrual Disorder.

Dr. Young, N. A. Jour. of Hom.: April 26, 1894; woman, age thirty-two, married, housewife. Has sticking and drawing pains in the muscles all over the body. These come, last for a time, and then are better for a short period. They are worse at night. Gets cold easily, which amel. the pains, but warmer wraps also amel. the pains. They wake her from sleep. All the body is very sore to touch; even pressure of bed clothes hurts her. Can get relief neither in bed nor on her feet. Always very thirsty. Tongue brown and thickly coated. Menses irregular and scanty. Profuse cold sweat all over body at night Lachesis, one dose.

May 8, 1894, pains all gone. Soreness, sweat and thirst also gone. Tongue clean. No other medicines or adjuvant treatment. No return of symptoms.

Iris versciolor in Threatening Abortion.

Very sensitive to the touch; pain across umbilicus, with severe griping at short intervals; nausea and vomiting of green or yellow bile, with eructations of a great deal of flatus during and between times of vomiting; diarrhea of a yellow, bilious character; miscarriage.—Dr. Danforth.

Pędiatrigs.

Prevention and Treatment of Gastro-Enteritis.

Dr. Seibert (N. Y. Med. Jour.): The infectious origin of gastro-enteritis is to-day a recognized fact, and in view of this our first idea must be prophylaxis. Of the causes probably the most common is septic matter carried from the vagina of the mother by the finger of the obstetrician; others are midwives, fennel tea, sugar nipples, cathartics and filthy breast nipples.

The first imperative indication in all cases is to remove the remnants of food, bacteria and ptomaines from the stomach

and intestines.

In the severest forms, called cholera infantum, energetic stomach washing must be performed; the colon should also be washed twice daily. If hyperpyrexia is present the water should be cool, and even cold.

The second chief indication is the absolute prohibition of milk, human and animal, during the first three days of illness, for this is one of the best culture media known. Underfeeding of the child with water, gruels and strained soups is better.

Metrorrhagia in Young Girls.

Dr. Castan (Jour. de Med. et de Chirurgie Pratiques): The larger number of writers on this subject have believed metrorrhagia in young girls to be due either to metritis or to a cardiac affection. Investigation has led him to conclude that aside from the metritic form and that of cardiac origin, there is also to be found in virgins metrorrhagias without lesions, constituting in itself a clinical individuality and often following puberty. They are caused by auto-infection, and in the majority of cases are amenable to general treatment alone. It is especially important to recognize their principal characteristics. In a young girl of from 13 to 16 years the beginning of the menstrual epoch may be followed by a continuous or an intermittent flooding-more frequently the former-which may either follow the first sickness or at a consecutive period, the second or third in some observations. Some young girls flow the entire month, and often the arrest of the hemorrhage can be attributed only to artificial means: prolonged rest in bed, hemostatic medication, appropriate injections; but in spite of everything it returns as often as the patient affords an occasion for it or only allows a possibility of it. The amount is variable, very often only a simple bloody oozing appears at the

vuiva, at other times profuse enough to be almost fatal. The blood is generally fluid, sometimes clotted, but this condition is generally associated with cases accompanied by pain. There are forms of dysmenorrhea found in young women that are characterized by the classic expulsive colic pains, with sometimes the production of a cast of the uterus; these cases are. however, infrequent. Often the disease terminates without the patient having felt the least pain at all, and it is only after the hemorrhage has continued for a long time that she may complain of a heaviness in the pelvic region, but nothing of the sharp pains that characterize parametritis in the course of acute affections or ovarian or other neuralgias in this region. Leucorrhea is rarely seen in this class of cases, and belongs more particularly to the metritic form. Nothing more can be learned by bimanual examination, or even with the speculum, and the general state often remains very good, and after a thorough examination only the one invariable symptom, hemorrhage, is found. The hemorrhage that appears under these conditions well merits the name essential, for it accompanies serous which are very insignificant. It is not always easy to discover the cause of it.

Dr. Castan attaches great importance to constipation, which he found in almost all cases of this kind. Indeed, constipation may act as a causative factor to it, not only in a mechanical manner, but also in a toxic manner. Moreover, it is often observed as a cause of hemorrhage in other situations, as retinal hemorrhages, or into other parts of the eye, and patients should be carefully questioned regarding the frequency and consistency of their stools. Constipation causes stagnation in the body of products to a high degree toxic which are intended to be eliminated; ptomaines, all the derivatives of putrefaction composing nitrogen, phenol, indol, skatol, etc., remain in the intestine for a more or less longer time, a part at least of which is absorbed, giving rise to nervous symptoms—a condition of stercoremia. This is the most frequent cause of the hemorrhage, and is rendered more easy by the embarrassment of the uterine circulation caused by its proximity.

The metrorrhagias of young girls are amenable to a general hygienic treatment, and in that manner should be treated first. Hydrotherapy, massage, moderate exercise are the first means to be employed.

Ozone Inhalations in Whooping-Cough.

Dr. Doumer (Nord Médical) reports his experience of this method, which Labbé and Oudin found very successful in fourteen cases. He treated five cases—brothers, sisters and mother, all suffering from whooping-cough of a fortnight to a

month's duration, with paroxysms of medium severity, varying in number from twenty to sixty a day. The ages of the patients ranged from three to thirty-five years. The treatment consisted in the inhalation of ozone for ten to fifteen minutes twice a day. The results were as follows: In four cases, in which sleep at night was much broken, there was improvement after four inhalations. In one case, in which vomiting was severe, it was speedily checked. In all the cases there was diminution both in the frequency and in the severity of the paroxysms from the second day, discontinuance of the inhalations, however, being always followed by relapse. A cure was effected after twelve to twenty-seven inhalations—that is, in nine to fifteen days. There was no relapse in any of the cases two months and a half later.

Glandular Fever of Children.

Dr. Joy (The Therapist): Under the name of glandular fever E. Pfeiffer has recently described a condition or disease observed in childhood which he contended was an acute specific fever previously unrecognized. The symptoms set forth by him, and as a whole concurred in by Filatow, of Moscow, are briefly as follows:

The patient, a child usually between two and four years of age, though occasionally older, is taken suddenly ill with a rise of temperature to 101 degrees to 103 degrees F., anorexia, and sometimes vomiting, headache, coated tongue and occasionally ill-defined abdominal pain. The most characteristic symptoms are, however a decided stiffness of the neck with pain on movement of the head, slight difficulty of deglutition and tenderness in the anterior triangles of the neck. There may at first be some undue redness of the pharyngeal mucous membrane and tonsils, but throughout the whole course of the disease nothing like a definite pharyngitis or tonsillitis.

On the second or third day a swelling develops in the neck, which is found to be due to an enlargement of from one to three lymphatic glands, which can be felt under the sternomastoid muscle and along its anterior border. These glands, which are tender upon pressure, continue to enlarge for from two to five days, sometimes attaining the size of a walnut; then after remaining stationary for a few days they begin to diminish in size, complete resolution taking place in three or or four weeks.

With the appearance and during the course of the glandular enlargement the temperature rises somewhat higher than at the onset—104 deg.—and falls by lysis when the enlargement has reached its height.

Almost invariably the glands first affected are those of the

left side, and the pain on movement causes the head to be inclined toward the affected side. In the majority of cases, when the glandular enlargement of the left side has reached its height, the glands on the opposite side begin to enlarge and pass through the same stages as those of the left side—namely, period of onset, stationary period, and the period of resolution. Pfeiffer asserts that there is inwardly enlargement of the liver and splenic enlargement in more than one-half the cases.

The disease is mild, is never the direct cause of death, but it leaves the child markedly anemic and depressed, complete recovery from which requires several weeks or even months.

Suppuration is extremely rare. Dr. Dawson Williams in a most excellent article upon the subject, with reports of numerous cases, cites no instance of suppuration having occurred. Filatow, however, reports two cases of suppuration. One of these had reached the beginning of the period of resolution, when the child fell, striking on the side of the neck affected. The fever recurred, followed by a phlegmonous inflammation of the glands previously deceased, and necessitated surgical aid.

In the second case suppuration occurred in the second week

of illness, for which no cause was obtainable.

The etiology of the affection is as yet very uncertain. Filatow considers the condition as purely idiopathic and makes no attempt to trace out etiological factors. In the cases of which reports have been obtained and in those which have come under my own observation, no casual factors could be found.

The symptomatology of cases observed by the writer followed very closely that outlined by Pfeiffer, Filatow, and Williams. The most distinctive point is the fact that the glandular swelling occurs without apparent involvement of the pharynx or tonsils, and in the absence of other disorders ordinarily accompanied by glandular enlargement, as eczema capitis, dental caries, and inflammatory diseases of the ear. The swelling is of a compact, slightly elastic consistency, the skin covering it sometimes, though not always, slightly reddened but not edematous.

The differential diagnosis presents little difficulty. Adenitis occurring secondarily to the diseases previously mentioned is easily excluded by examination of these parts. The disease might, upon superficial examination, be mistaken for parotitis. The swelling accompanying parotitis occupies precisely the region of the parotid gland, beginning immediately below and in front of the ear, which is pushed slightly upwards, the swelling extending forward over the cheek. The swelling accompanying glandular fever does not involve the face, but is found under and among the anterior border of the sterno-mastoid muscle.

The statement has been made and some evidence put forth to show that the so-called glandular fever is merely an atypical form of mumps, in which the lymph glands of the neck are involved without any involvement of the parotid or other salivary glands. This, I believe, is not correct. A single attack of mumps-bilateral-renders an individual immune from future attacks, while many cases with the symptoms of glandular fever above noted are recorded where the patients had previously suffered from an attack of mumps. reports of Dr. Park West, of New York, seem also to refute the idea of the disorder being an atypical manifestation of He reports an epidemic which began in 1893 and ended in 1896, giving a total of ninety-six cases occurring in children between seven months and thirteen years of age. characteristic feature was the involvement of the several glands, beginning in a majority of the cases on the left side, accompanied with fever and later with enlargement of the corresponding glands of the opposite side. The spleen was enlarged in about one-half the cases and the liver in nine-tenths of them. Most of the cases were accompanied by obstinate constipation. In the milder case there was slight diarrhea, or constipation alternating with diarrhea. The duration of the disease was from nine to twenty-seven days. No instances of suppuration occured. In none of these cases were the parotid or any of the salivary glands affected, nor was there a case of mumps in the district during the entire time of the epidemic.

As to the pathology of the disease, nothing is at present known.

The treatment is purely symptomatic. No line of treatment seems to alter the course of the disease.

Obstetrics.

Pain and Menstrual History in Extrauterine Pregnancy.

Dr. Heist: A woman suffering with pelvic pains and amenorrhoea may be supposed to have an extrauterine pregnancy in the absence of a history pointing to an old pyosalpinx or to other pelvic inflammation. The three cardinal symptoms of ectopic gestation are: (1) Pain, sharp and agonizing, occurring in paroxysm, appearing at any time from a few days to months after a normal menstruation; (2) cessation or irregu-

la-ity of menstruation, often with the discharge of what the patient calls "pieces of flesh"; (3) tumor, which appears as a small swelling in the tube, at first not larger than the end joint of one's thumb, and adherent; later a sensitive mass fixed in the pelvis by thick, velvety adhesions.

Prolonged uterine bleeding, followed by the discharge of the decidua, is the almost universal rule at some period in the

history of a tubal pregnancy.

Treatment of Post-Partum Hemorrhage by Abdominal Bandage.

Dr. Enrico Sava (Archivio di Ostetricia) has met with a grave case of post-partum haemorrhage from inertia of the uterus, in which, after various measures had been tried without result, the bleeding was successfully arrested by bandaging the abdomen. After all the clots have been expressed from the cavity of the uterus, the fundus is drawn over to the front and made to rest upon the symphysis pubis in such a fashion that its posterior surface looks directly upward. Then a bandage is passed tightly around the abdomen, immediately above this level, so as to keep the uterus in this position of forced anteversion. The idea was suggested to Sava by what naturally occurs to the uterus in abortion. He thinks the method is to be preferred to packing the uterus and vagina, etc. simple, and can be carried out by the midwife or nurse. It stimulates the external, not the internal, surface of the uterus. The danger of concealed internal haemorrhage is avoided, and the risk of puerperal infection is greatly lessened. Further, it produces a kind of autotransfusion, a large quantity of blood being sent to the nervous centres.

Paraplegia in a Parturient Woman.

Dr. Routh (La Presse Medicale) reports the following interesting case: Multipara, seven months pregnant, fell from the height of fifteen feet, fracturing the spine at the sixth dorsal vertebra, complete paraplegia resulting. Patient came in labor one month later, almost at term. The contractions of the womb were entirely without pain; dilatation of the cervix was complete in ten hours and the child born two hours and a quarter later. Uterine involution and lactation were normal. Patient died six months later.

After a thorough review of the literature on this subject the author makes the following deductions:

I.—Conception is possible in paraplegics. Labor follows at term without pain and is followed by a normal involution.

2.—The parturient act is partly automatic, partly reflex; automatic during dilatation of the neck, reflex in expulsion of the fetus.

3.—The functions of the brain are not indispensable for co-

ordinating the action of the womb. However, the cerebral functions appear in normal cases to regulate the contractions and to render them distinctly intermittent.

4.—Communication of the uterus with the lumbar enlargement of the cord is indispensable for the purpose of causing

retraction of the uterus.

5.—When the lesion that causes the paraplegia is low enough to cut off the impulses from the cord the womb is still capable of expelling its contents by its own neuro-muscular resources, but toward the end of labor the reflex conditions necessary for the expulsion of the fetus being cut off this last phase of labor is irregular and cannot spontaneously terminate, as shown by the experiences of Simpson and of Bracket.

Influence of Morphine, Ether and Chloroform on Labor.

Dr. Hensen (Am. Medico-Surgical Bull.) from observations made in the Clinic at Keil comes to the following practical conclusions: Morphine in doses of 0.005 to 0.02 (I-I2 to I-3 grs.) has no influence whatever on the pains or on the pressure of the abdominal muscles.

Ether causes in from one to two minutes a diminution in the strength of the pains and a prolongation of the intervals between the pains. In five to twenty minutes after discontinuing the ether the pains commence with the same strength as befor**e**.

Chloroform also diminishes the pain and prolongs the intervals between the pains the same as ether does, but the latter has a great advantage over the former. While after ether the activity of the uterus is re-established in a few minutes, after chloroform the uterus sometimes fails to contract for as long a period as two hours.

It is therefore of importance in obstetrical operations, such as forceps extraction, turning, etc., where a speedy re-establishment of uterine contractions is highly desirable, ether, and not chloroform, should be employed. Many a haemorrhage following uterine inertia may be ascribed to the employment

of chloroform.

Modern Obstetrics.

Dr. ..Iontgomery: From the information I can gather on this subject I find that we are only a few steps in advance of our fathers of fifty years ago. I do not deny that many lives have been saved by the modern obstetrician, but who can count the number of mothers sleeping the everlasting sleep of death as the result of the indiscriminate and unskillful use of the forceps. He who applies the forceps simply for the purpose of saving time places time above the life of the mother

and her unborn child. I know that it requires patience to sit and count the stars through cracks of the log cabin when we

have calls urging us to the palace.

A source of much harm in my opinion being practiced today is the vaginal douche. Professor Luck, according to "Modern Medicine," expresses himself as strongly opposed to the vaginal douche before and after parturition. While the vaginal canal abounds in micro-organisms, he considers that they only intensify the acid reaction of the vaginal secretions and render the latter especially unfavorable to the multiplication of the streptococcus, said by many to be the germ that produces puerperal septicemia. The normal vaginal secretions furnish a soil hostile to all forms of cell growth. The cervical canal of the pregnant woman is protected from the invasion of micro-organisms by a mucous plug, and thus in natural labor the protection of the uterine cavity is complete. The entire parturient act furthermore serves to guard the woman against infection.

With the rupture of the membranes the downward current is produced by the escape of the amniotic fluid. The descent of the child cleanses the vaginal canal, and the increase of the vaginal secretions is inimical to the action of the septic germ. Finally, the passage of the placenta completes the toilet of the vagina. The fact that nature provides this excellent means of self-defense clearly shows that the disturbing method of disinfection employed before and after labor, under the plea of prophylaxis, is not commendable. The antiseptic douche dissolves the mucus, sets free imprisoned germs, weakens the resistance of tissue, and contributes to the extension of the

source of infection.

Meddlesome midwifery is wrong in every case in which it is practiced. Are the forceps used many times now where they were used very rarely years ago? I think so, and would ask you if the comparative results justify this use. Are there not other means to alleviate the pains of the parturient woman and assist nature in her efforts to complete labor, other than forcibly dragging the child into the world, often before the parts are ready for its passage, the only excuse being that labor nas lasted twenty-four or thirty-six hours? Are we not making too frequent examinations? The condition having been ascertained to be normal, diagnosis of position made and degree of dilatation of os known, is it necessary to annoy and often endanger the health or life of the woman by frequent examinations, often prompted by our own impatience? Are we not often rupturing the membranes too soon, and are we not leaving our cases in the care of nurses, telling them only to send for us when they are sure of a speedy completion of the labor? Is this not leaving them to act for us, and by our commands one of the worst forms of meddlesome midwifery, as they can only ascertain what we require them to know by unskilled, frequent examinations? The second stage completed, are we not in too great a hurry to cut a pulsating cord and forcibly express the placenta or introduce the hand to remove it? Would it not be more scientific to wait a reasonable time for its separation and expulsion, and allow nature to complete the third stage, as well as the first and second? Is not any interference with normal labor, or any other, aside from assisting nature should she flag in her efforts toward its completion, unless demanded by threatening danger to the mother or child, meddlesome midwifery? Are we not in our great haste losing sight of our obligation to consider the interest of the mother and child as paramount to all others, no matter what outside interests suffer by our detention by the bedside? From the time we enter her room and take charge of the case our duty is to her and her unborn child only. Needless hurrying the labor or leaving too soon after the birth of the child violates that obligation.

Accidental Hemorrhage.

Dr. Gottschalk (Centralbl. f. Gynäk.) related an instructive case of partial detachment of the placenta at the February meeting of the Berlin Obstetrical Society. The patient was a primipara, aged twenty-eight, and suffered from the nephritis of pregnancy. Labor came on at the end of the eighth month. The presentation was right occipito-anterior, with prolapse of an arm. The os having attained the diameter of a florin, the membranes were ruptured in order that combined version might be undertaken. At once thick clots and liquor amnii, like pure fluid blood, escaped; the membranes remained attached to the lower segment of the uterus. The fingers passed into the uterus detected the lower border of the placenta detached from the membranes. Then it was found that the entire placenta was separate, excepting the uppermost part, which was still attached to the uterine wall, high up to the left. The amniotic cavity was full of coagula, and there were big clots underneath the placenta. After careful detachment of the upper part of the placenta, the foot was seized and the child delivered with great difficulty, as the uterine contractions were very strong, though the patient was deeply under chloroform; the placenta followed. The child died early in labor; the mother recovered rapidly. Gottschalk believed that hemorrhage into the amniotic cavity was due to the clot behind the detached placenta being forced through the damaged placental walls by the uterine

contractions early in labor, when the membranes were still firmly attached to the lower segment. Winter was of an opposite opinion; he contended that as the clots and blood came away when the membranes were ruptured, that showed that the blood came away from under the detached placenta directly pressure was removed and the membranes partly separated below. He had seen that phenomenon repeatedly during version, when there was no evidence of rupture of the placenta by the pressure of large clots behind it during a pain. The Use of the High Forceps.

Dr. Toth (Arch. f. Gyn.) deals with this question, with special reference to the contracted pelvis. He refers to the different fashions that prevail as to the use of the forceps, the frequency in head presentations varying from I or 2 to II or I2 per cent. In Buda-Pesth, among 7,775 births in fifteen years, the forceps were used 155 times; that is, in 1.9 per cent of the cases. Forty four cases of high forceps came under the author's observation, falling into three groups: (1) With normal pelvis, ten cases; (2) with contracted pelvis, twenty-four caes; (3) unsuccessful applications, followed by craniotomy, ten cases. In the first group the indications were uterine inertia, protracted second stage, with danger to mother or child; undue stretching of the lower uterine segment, with risk of rupture of the uterus; seven of the children were saved; two of the others weighed 114 pounds and 124 pounds, respectively. In the second group twenty-one children were saved and twenty-three mothers. In the third group perforation was performed on the living child seven times, and on the dead child three times. One mother died of rupture of the uterus and peritonitis. In this case the assistant, contrary to the practice in vogue at the clinic, turned after the high forceps had failed, and then had to perforate the after-coming head. The indications were: Delayed dilatation and failure of the head to engage, two cases; threatened uterine rupture from undue stretching of the lower uterine segment, seven cases; embarrassed breathing, with severe nephritis, one case. After quoting and comparing many statistics, the author sums up in the following conclusions: (1) The use of the high forceps is not so dangerous, either for the mother or for the child, as is commonly supposed; on the contrary, it gives undeniably better results for both than turning, especially from a head to foot presentation. (2) In general, where labors must be terminated in the interest of the mother, then. if conditions are no longer applicable for turning, the high forceps should be tried before perforation of the living child is resorted to. (3) In cases of generally contracted pelvis of the first and second degrees, where the narrowing affects especially the upper straits, the high forceps should have the preference over turning, after a due period of waiting has shown that a spontaneous termination of labor is still possible. The same principle should guide us in those cases where the disproportion is due to a relatively large child, while the pelvis is of normal size. (4) In cases where the high forceps has failed, further waiting is not permissible, but perforation must at once be resorted to. Under favorable circumstances symphysiotomy may be considered as an alternative but turning (into a foot presentation) is contra-indicated, and must be decisively rejected. (5) The high-forceps operation can be performed with any instruments of convenient length; but the author has been repeatedly convinced of the superiority of Turner's axis traction over other high forceps.

Albuminuria During Pregnancy.

Dr. Charles (Jour. d'Accouchements) relates two cases. In one, a primipara at the eighth month, the treatment adopted, consisting of milk diet, diaphoresis and purgation, brought on premature labor. The child died eighteen hours after delivery; the mother recovered from her confinement, but albuminuria persisted. The prognosis in her case was bad.

In the second case, also a primipara, albuminuria existed before pregnancy. For three months she remained fairly well under careful treatment; but after a long railway journey, followed by exposure in wet weather, the symptoms became worse, and she died of uremia at the fourth month.

The author recalls the conclusions of his previous researches

on the subject—namely:

1. In most pregnant women there is a certain degree of autointoxication; that is the normal toxemia of pregnancy.

2. In lesions or disease of the kidney or liver the toxic condition becomes aggravated, and may lead to grave complications, notably uremia.

3 Toxemia of renal origin is the most common, associated with albuminuria and edema.

4. Albuminuria is not the cause of eclampsia, but a symptom owning a common origin.

5. Grave complications, such as coma, dyspnœa, paralysis,

may prove fatal in the absence of eclampsia.

6. In most cases toxic eclampsia breaks out in albuminuric women; albuminuria is therefore an important precursory sign, which should not be neglected.

7. The author's statistics show that one pregnant woman in forty is albuminuric, and that of four albuminurics one develops eclampsia; eclampsia without albuminuria is rare—one in nine—and is less serious.

- 8. Albuminuria alone, without eclampsia, has often serious or fatal consequences—in 110 cases, eight women and twenty children died; there were sixty-one premature labors, eight post-partum hemorrhages, and three cases of threatened convulsions.
 - 9. Albuminuria should be looked for in all pregnant women.
- 10. Every albuminuric pregnant woman should be actively treated, a milk diet being the best.
- 11. In case of threatened danger premature labor is indicated, and gives excellent results.

Three Normal Pregnancies after Nephrectomy.

Dr. E. Tridondani (Ann. di Ostetricia) gives an interesting instance of the reproductive history of a woman who had had a kidney removed. A patient, aged twenty-nine, came into the Maternity at Pavia, suffering from symptoms resembling those of intestinal obstruction, accompanied by pain on micturition and scanty urine. She was in the eighth month of pregnancy, and to the left side of the uterus was a fluctuating tumor. Under treatment the symptoms improved, and the woman was spontaneously delivered of a male infant. Three months later the abdomen was opened, and a cystic kidney (the left) was removed; the recovery was complete. Since then the patient has had three pregnancies. In none of the three were there any abnormal symptoms; no edema, urine normal in quantity and quality. The labors were at the full term and non-instru-The placenta and membranes in each case were healthy, and the puerperium was normal. The infants were born alive, were healthy, and had a weight and size above the average. The author concludes from the study of this and the three other reported cases that pregnancy occurring in a woman with one kidney does not interfere with her health; that the absence of a kidney does not disturb the progress of gestation, labor and the puerperium, and that the product of conception does not suffer. He does not, therefore, agree with Schramm, who advises a woman with a single kidney not to marry, or, if married already, not to become pregnant. It is noteworthy that in the above case the liquor amnii was increased in amount; but it is doubtful whether this was a consequence of the absence of one of the mother's kidneys.

Treatment of Eclampsia.

Dr. Charpentier (Sem. Méd.), claiming to represent the French school, says that, when the patient was seized with eclampsia and labor appeared spontaneously, all were agreed that the right treatment was to terminate labor as quickly as possible. But when eclampsia set in before labor, a distinction

must be made between cases at or nearly at term, and those earlier in pregnancy. The German school consider the induction of premature labor, or even abortion or forced delivery. the only treatment. Dührssen incises the cervix deeply, and if necessary the vulva and perineum; Bossi uses instrumental, others manual dilatation; others, again, would resort to Cæsarean section. Charpentier is convinced that induction of labor is useless and forced delivery dangerous. He concludes that: (1) The urine of every pregnant woman should be examined. (2) If the least trace of albumin is found, she must be put on a strict milk diet, which prevents the production of toxins; this must be continued till after labor and till no albumin is present. (3) When edema without albuminuria is found the milk diet is indicated. (4) Whenever eclampsia occurs with cyanosis in a strong woman, bleeding up to half a litre must be performed. (5) Chloral should be given. (6) When convulsions have set in, milk should be given by the mouth, or, if necessary, by the esophagal tube; this alone sometimes causes cessation of the convulsions. Besides this, the fits should be treated with chloroform inhalations, and diuresis induced by subcutaneous injection of normal saline solution. One must then wait till normal labor sets in. If there is inertia uteri, labor must be terminated by forceps or version if the child is alive, by basiotripsy if dead. Induced labor is only exceptionally necessary, and forced delivery never. Halbertsma, Mangiagalli, Bossi, Pasqualini and others spoke on the other, or "German' side, and advocated early emptying of the uterus, very favorable statistics being brought forward in support of this.

Vomiting of Pregnancy.

The following treatment is suggested by Dr. Bacon (Jour. of Mcd. Sciences):

- 1. The abnormal irritability of the nervous system, including the vomiting centre, is to be allayed by keeping the patient in the horizontal position, by attention to the skin, bowels and kidneys, using rectal and, if necessary, hypodermic injections of salt solution.
- 2. The hysterical condition which is so commonly present should be controlled by strengthening the will and influencing the dominant idea of the patient.
- 3. All sources of peripheral irritation should be discovered and treated.
- 4. In extreme cases subcutaneous saline injections serve the threefold purpose of (a) dilating the blood and increasing vascular tension: (b) eliminating toxins through renal and intestinal emunctories: (c) furnishing two important kinds of feed.

5 Induction of abortion is never indicated. At a stage when it is safe and efficient, it is not necessary, and in extreme cases it adds greatly to the danger, rarely stops the vomiting, and can be replaced by the artificial serum.

Gynecological Examination of Women after Labor.

Dr. Doléris (Bull. Soc. Obst.) dwells on the importance of a careful vaginal examination during the puerperium before patients are discharged from the medical attendant's care. He believes that a large proportion of such patients carry away from their confinement the seeds of most of the pelvic troubles to which they are subject later on. Examination is specially necessary when the puerperium has been attended by any signs of infection, and should embrace (1) bimanual examination; (2) inspection of the vulva, vagina and cervix; (3) investigation of traumatic lesions of the cervix and of the condition of the cervical mucosa; (4) culture examinations of the cervical secretions; (5) catheterization of the uterine canal, with dilatation if necessary. This will often show the presence in the uterine canal of an abundant brownish or creamy liquid, in which in infectious cases pathogenic micro-organisms are constantly found. The infective condition, which is often complicated by displacements and subinvolution, should be vigorously treated before the patient leaves hospital. or her home. Intrauterine irrigation and drainage should be combined with hypodermic injections of ergotine. In cervical lacerations with eversion, applications of creosote and glycerine (1 in 5) and insufflations of iodoform answer well. The author further recommends the daily injection of 100 to 200 c.cm. of artificial serum as a stimulant and tonic agent. For displacements he employs the Hodge pessary in the case of retroversion, and the use of tampons for several weeks in cases of prolapse and colpocele. Treatment on these lines is prophylactic, and will avert many subsequent troubles and more serious complications.

Central Laceration of Perineum.

Dr. Lambertenghi (Annali di Ostetricia) records an unusual case where this rare accident occurred. The patient was seventren; the pregnancy had been normal, the vertex presented in the first position. When the os was fully dilated the head was in the pelvic cavity. It was found that the head could then be moved on an axis drawn from the symphysis pubis to the left ilio-pectineal eminence; hence there was suspicion that a hand had prolapsed. The head advanced slowly, but the vulvar ring did not dilate fully; it held back the head as though it were a very firm gutta-percha band, and extension was thereby greatly impeded. Just as the parietal eminences appeared at the vulva, and rupture of the fourchette and perineum in

the usual manner seemed imminent, a rent opened in the centre of the perineum and the right hand protruded. Then the head was delivered through the vulva, and the whole right forearm up to the elbow was forced out of the central laceration. The prolapsed limb was easily disengaged and brought into the vagina. The child was delivered; it was slightly asphyxiated. It weighed over 5 pounds 8 ounces; the biparietal diameter was 3 3-10 inches. The central laceration was closed with three deep silkworm gut sutures; they were removed on the sixth day; union was complete by second intention, and the patient made a very good recovery.

Saline Injections After Flooding.

Dr. Amillet (L'Obstétrique) insists that after grave hemorrhage in pregnancy or labor a saline intravenous injection is the best method for encountering acute anæmia. A I per cent solution of chloride of sodium is the only available mixture which has no evil influence on the corpuscles. At least 1,500 to 2,000 grammes must be injected. In less serious cases 200 grammes can be injected under the skin; more than one dose may be required. Amillet recommends an intravenous saline injection or a subcutaneous injection before any obstetrical operation is performed on a woman exhausted by loss of blood. When the patient has clearly been revived by these means, she must, in any case, be closely watched, as sometimes the good effects do not last. The injections must be repeated if necessary till all danger has passed away.

Cynecological Plahings.

Metrorrhagia and Heart Disease.

Dr. Dalché (Rev. Méd.) finds that menorrhagia is a frequent and almost necessary complication of the earlier stages of certain forms of valvular disease. When asystolism and cardiac cachexia set in, this symptom, as might be expected, is replaced by amenorrhæa. On the other hand, menorrhagia not rarely precedes the physical signs of heart disease; then it continues after they become evident as long as the compensatory changes in the heart remain available. When breathlessness, vertigo, slight irregular action of the heart and malleolar edema appear, the menorrhagia is at its height. This variety of uterine

disease is especially common in mitral contraction, less frequent in mitral insufficiency, rare in aortic disease, and rarer in valvular disease of the right heart. In congenital cardiac disease it practically does not exist.

Uretero-Vaginal and Uretero-Abdominal Fistulas.

Ferguson, of Chicago (Amer. Gynec. Jour.), has compiled a useful monograph on these serious complications, including two cases in his own practice. From the study of sixty-seven cases he draws the following conclusions: (1) The left ureter is more frequently the seat of trouble than the right. (2) Ureterovaginal is much commoner than uretero-abdominal fistula. (3) The most common cause is difficult labor, especially when the forceps are used. (4) Of all the operations performed in the pelvis, vaginal hysterectomy is the most frequent cause of ureteral fistula. (5) Other conditions being favorable, all cases of ureteral fistula are curable by operation. In uretero-vaginal fistulæ the direct method of operating should be selected, and no particular operator's method is suited to all cases. Intraperitoneal operations are suitable for uretero-abdominal fistulæ. (6) For the cure of uretero-vaginal fistula it is absolutely unjustifiable to perform hysterectomy, nephrectomy or colpocleisis. When septic infection of a kidney occurs it may be necessary to open and remove it. To remove a kidney or uterus, or to close the vagina in these cases of simple fistula, bespeaks lack of surgical ability. (7) Another unsurgical procedure is transplanting the cervix uteri into the bladder in cases of uretero-uterine fistulæ. It causes sterility, directs the menstrual flow into an abnormal channel, and renders possible a backward flow of urine into the uterus and fallopian tubes, and even the peritoneum. (8) Uretero-enterostomy is only justified when no other operation is feasible. It has but little to recommend it on general principles.

Tubal Hemorrhage Independent of Tubal Pregnancy.

Bovée, of Washington (Amer. Gynec. and Obstet. Jour.), strongly dissents from the current teaching that pelvic hæmatocele is always due to ectopic gestation. He publishes a case which he classifies as tubo-ovarian hemorrhage, resembling ectopic pregnancy. Bovée's patient was a colored woman, aged twenty-three, married, not pregnant since four years ago, but subject to pelvic pains for five years. Her period had been regular, but the last came on, after slight delay, with pain, and continued for a fortnight freely. Then she was examined; she appeared anæmic and exhausted. A mass was felt above and to the left. At the operation this mass proved to be the left fallopian tube greatly dilated and full of blood clot, uncomanized and readily separated from the tubal wall. The carel

of the tube communicated with a blood sac in the ovary by a short sinus, which consisted of the groove in the ovarian fimbria of the tube bridged over by adhesions. The tube was protected by adhesions to the omentum, but the wall of the cyst in the ovary had given way, and a considerable quantity of clot had escaped into the peritoneal cavity. There was no histological evidence of tubal pregnancy, but there had evidently been hemorrhage into the ovary—an ovarian apoplexy, as some authorities term it. Bovée quotes, as supporting his opinion that internal hemorrhages from the tube and ovary are not always the result of tubal pregnancy, Scanzoni's case of fatal rupture of the ovary during menstruation. Bovée does not dwell on the fact that earlier writers had not the assistance of histologists, who could detect chorionic villi in clot, but he rightly concludes that to ignore published evidence of the frequent occurrence of hemorrhage from the ovary and tube, due to inherent disease of those organs, independent of impregnation, and to continue to diagnose ruptured ectopic pregnancy without microscopical or other certain evidence, is to ignore scientific truths and to foster false pathology.

Operations on the Uterine Appendages.

Dr. J. Coplin Stinson (Occidental Med. Times) recommends that in operations upon ovarian cysts and cystic ovaries any portion of ovariantissue which appears normal, even though small, should be retained. Resection and plastic operations should be practiced in women when pregnancy is liable to occur and delivery at term can be conducted with safety. The writer emphasizes his views by the record of two cases of adherent and retroverted uterus with enlarged, prolapsed and cystic ovaries, in which he excised the cysts from the glands and sutured their cut edges with fine silk. In each case the result was satisfactory; in the first, a woman thirty-five years of age, there was a disappearance of all pelvic symptoms, and in the second, the operation was followed by regular menstruation without pain or other morbid symptom.

Vaginismus.

Dr. Vedeler (Monats. Gynäk.) believes that Rode and others have confounded vaginismus with dyspareunia. The former is always of hysterical origin, and Vedeler declares that it often disappears spontaneously, without treatment. The result of various operations for vaginismus is misinterpreted by many authorities. It is the hysteria that is cured by surgical interference, and with it the principal symptom in these cases—namely, hyperæsthesia.